COMPANION LIFE INSURANCE COMPANY
INDIVIDUAL APPLICATION FOR INSURANCE

DO NOT LEAVE ANY BLANKS

Plan Option _____

- ❑ **New Enrollment**
- ❑ **Change of Family Status**

_____ _____
Description of Change in Family Status Date

Select Coverage Type:

❑ **Employee Only** ❑ **Employee and Spouse** ❑ **Employee and Dependent Child(ren)** ❑ **Family**

Employer Name _____ **Group Number** _____

Location Number (If Applicable) _____ **Effective Date** _____

EMPLOYEE INFORMATION

Employee Name _____ **Social Security Number** _____

Home Address _____
Street **City, State** **Zip** **Home Telephone**

Gender
- ❑ **Male**
- ❑ **Female**

Date of Birth _____

Date of Hire _____ **Average Number of Hours Worked** _____ **(per week)**

Marital Status
- ❑ **Single**
- ❑ **Married**
- ❑ **Divorced**

Life Insurance Beneficiary _____

Beneficiary Relationship _____

DEPENDENT INFORMATION

Dependent Name	Gender	Date of Birth	Relationship	Full-Time Student	Social Security Number
	❒ Male ❒ Female			❒ Yes ❒ No	
	❒ Male ❒ Female			❒ Yes ❒ No	
	❒ Male ❒ Female			❒ Yes ❒ No	
	❒ Male ❒ Female			❒ Yes ❒ No	
	❒ Male ❒ Female			❒ Yes ❒ No	
	❒ Male ❒ Female			❒ Yes ❒ No	

EMPLOYEE AUTHORIZATION

- ❑ I ELECT TO PARTICIPATE IN THE PLAN AND AUTHORIZE MY EMPLOYER TO MAKE DEDUCTIONS FROM MY PAYCHECK, IF APPLICABLE.
- ❑ I HAVE BEEN GIVEN THE OPPORTUNITY TO PARTICIPATE, BUT I ELECT **NOT TO PARTICIPATE** IN THIS PLAN DUE TO:
  - ❑ Currently Covered Under my Spouse's Health Insurance Plan
  - ❑ Currently Covered by my Employer's Comprehensive Major Medical Plan or Medicare
  - ❑ Other _____

_____ _____
Employee Signature Date