GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST

Companion Life Insurance Company

P.O. Box 100102 • Columbia, S.C. 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

☐ New Employee
☐ Add/Increase Coverage
☐ Change Beneficiary
☐ COBRA
☐ Change Address
☐ Change Dependent Coverage
☐ Change Class or Status
☐ Terminate Coverage

Companion Use Only
Approved: ☐ Declined: ☐
Date:_____
By:_____

TO BE COMPLETED BY EMPLOYER

Name of Employer (Use Name from Group Billing Notice or Master Application)	Group No. (10 digit #)	DEPT/DIV (3 digit #)	CLASS
Houston Professional Musicians Assoc., Local 65-699, A.F.M			

TO BE COMPLETED BY EMPLOYEES

Social Security Number	Effective Date (Month / Day / Year)	Date Employed Full Time (Month / Day / Year)	Date of Birth (Month / Day / Year)	Hours Worked Per Week

Your Name: Last First M.I.

Sex: ☐ Female ☐ Male

☐ Weekly ☐ Monthly ☐ Annually (Do not include overtime or bonuses.)
Earnings $_____

Marital Status: ☐ Single ☐ Married

Occupation

Your Home Address City State Zip Code

COMPLETE FOR LIFE AND/OR DISABILITY

COVERAGE REQUESTED ☐ Basic Life Insurance ☐ AD&D ☐ Dependent Life Insurance ☐ Short Term Disability
☐ Long Term Disability ☐ Voluntary LTD

☐ Voluntary Life (Amount Selected)

	Life	AD&D
EMPLOYEE:	$	$
SPOUSE:	$	$
CHILD:	$	

Spouse Name: Last First Middle *(Voluntary Life Only)* Birthdate Social Security Number

Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for spouse coverage.)*
Last First Middle Relationship to Insured

COMPLETE FOR DENTAL AND/OR VISION

Coverage Requested: ☐ Dental For Employee Only ☐ Dental For Employee and Dependents
☐ Vision For Employee Only ☐ Vision For Employee and Dependents

Is your spouse to be covered? ☐ **Yes** ☐ **No**

Dental and/or Vision Coverage Is For (Check Box Below):
☐ Employee ☐ Employee plus 1 (☐ Spouse or ☐ Child) ☐ Employee plus 2 (☐ Spouse ☐ Child or ☐ 2 Children) ☐ Employee plus 3 or more

Are you or any of your dependents covered for dental insurance under another policy? ☐ Yes ☐ No

Complete for Dependent Coverage — Spouse Name (Last) (First) (Middle Initial)		Full-time Student Y/N	Date of Birth	Gender M or F	Do any of your dependents have any other dental coverage?	If Yes, Name of Carrier
			/ /		☐ Yes ☐ No	
CHILDREN	1		/ /		☐ Yes ☐ No	
	2		/ /		☐ Yes ☐ No	
	3		/ /		☐ Yes ☐ No	
	4		/ /		☐ Yes ☐ No	

REFUSAL OF GROUP INSURANCE

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Coverage Refused (Check All That Apply): ☐ Basic Life ☐ AD&D ☐ Dependent Life ☐ Voluntary Life
☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary LTD ☐ Dental ☐ Voluntary Dental

FRAUD WARNING (Not Applicable in AZ, FL, GA, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Your Signature
	X