Companion Life

Companion Life Insurance Company/Columbia, SC

Chamber Solutions Voluntary Dental Insurance Employer Participation Application For The Joint Employer Group Insurance Trust

EMPLOYER (APPLICANT) INFORMATION (Please Print or type.)

Legal Name of Employer: _____

Address: _____ City: _____ State: _____ ZIP: _____

Telephone: _____ Contact: _____ Title: _____

No. of Eligible Employees: _____ No. of Eligible Employees Enrolled: _____

Effective Date Requested: _____ SIC Code and Nature of Business: _____
(The effective date will be the first or 15th day of the calendar month coinciding with or next following the date of written acceptance by Companion Life.)

How many years in this business? _____ How many years at this location? _____

Tax I.D. No.: _____ No. of Family Members in Organization: _____

Plan Request: Chamber Solutions Voluntary Group Dental Program

☐ Dental Care 1200 Plan (Basic and Major Services)
☐ Dental Care 1200 Plan (Basic, Major and Orthodontic Services)
☐ Dental Care 1000 (Basic and Major Services)

Takeover Benefits: Apply only if prior plan was voluntary, employee-paid dental coverage.
In order for Companion Life to determine whether or not Takeover Benefits are to be included, the following must be provided:

a. Name of Prior Carrier: _____

b. Effective Date of Prior Plan: _____ c. Termination Date of Prior Plan: _____

The employer must also submit a copy of (1) the prior carrier's most recent billing statement; (2) a certificate or letter of acceptance that shows the effective date of the prior plan; and (3) the prior carrier's certificate, booklet or schedule of benefits. If prior carrier's bill does not include the effective date of each employee's coverage, please note this information next to each employee's name so we can give the correct credit for transfer of benefits.

Employment Elimination Period: ☐ 1 Month ☐ Other: _____
(No elimination period applies to those employed on the effective date.)
(Coverage following completion of the waiting period will be effective on the first or 15th day of the calendar month only.)

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.

Participation Agreement (Administered and underwritten by Companion Life Insurance Company)

The Employer hereby applies for Group Insurance Benefits as set forth in the above "Voluntary Dental Employer Participation Application for the Joint Employer Group Insurance Trust" and subscribes to the Agreement and Declaration of Trust.

Name of Trust: The Joint Employer Group Insurance Trust

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does the Trustee have any obligation under any policy of insurance and that all claims for the benefits provided by insurance being applied for herein shall be made to and payable by the Insurance Companies issuing group policy(ies) to the Trustees, but only to the extent and in strict accordance with the provisions of such policy(ies). The Trust agreement and the group policy(ies) held by the Trustee are available for inspection during regular business hours by the Participant at the office of the Administrator, Companion Life Insurance Company, located at 7909 Parklane Road, Suite 200, Columbia, SC 29223-5666.

_____
(Signature of Employer/Applicant)

_____
(Title) (Date)

_____
(Signature of Resident Agent/Broker)

_____
Print Agent's/Broker's Name License No.

HOME OFFICE USE ONLY Employer Group No.: _____
Takeover Benefits: ☐ Yes ☐ No

Accepted by Companion Life Effective: _____

By: _____
(Title) (Date)