GROUP MASTER EMPLOYEE ENROLLMENT FORM

Administered by:
Companion Life Insurance Company
800 Main Street
P.O. Box 1535
Dubuque, IA 52004-1535
Telephone Number: (877) 676-5789
Fax: (877) 557-3350

Underwritten by: Companion Life Insurance Company

Companion Life
P.O. Box 100102 | Columbia, SC 29202-3102
800-753-0404 (Phone) | 800-836-5433 (Fax)

Companion Life Insurance Company		Companion Life Use ONLY
□ New Employee	□ Change Address	Approved: □ Declined: □
□ Add/Increase Coverage	□ Change Dependent Coverage	Date: _____
	□ Change Class or Status	By: _____
	□ Terminate Coverage	

POLICYHOLDER INFORMATION – to be completed by the Policyholder or Group Administrator

Employer Name: McDowell Technical Comm. College DBA: _____

Group Number: 907-14-01454 Dept/Div Number: _____ Class: _____

ENROLLEE INFORMATION (PLEASE PRINT)–to be completed by the Employee /Enrollee

Last Name (Include Jr., Sr., etc.)	First Name		M.I.
Street Address	Apt Number	City	State/Zip
Social Security Number	Primary Phone Number Work Phone Number		Email Address
Male ☐ Female ☐ / Date of Birth(MM-DD-YY)	☐ Weekly ☐ Monthly ☐ Annually Earnings$_____ Do not include overtime or bonuses		
Marital Status ☐ Single ☐ Married / Occupation	Hours Worked Per Week _____		Hire Date: Coverage Effective Date:

COVERAGE SELECTION

☐ Dental ☐ Vision

DEPENDENT INFORMATION			Do any of your Dependents have any other coverage? *(Dental Only)*
Spouse Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No
Child Name	☐ Male ☐ Female	Date of Birth (MM-DD-YY)	☐ Yes If yes, Name of Carrier ☐ No

DEPENDENTS: Eligible Dependents are determined by your Employer's eligibility terms.

If More Space Is Needed, Please Attach A Separate Sheet, Signed And Dated By The Enrollee.

DENTAL

1. PLAN SELECTION

☐ Employee ☐ Employee + spouse

☐ Employee +children ☐ Family

VISION

1. PLAN SELECTION

☐ Employee ☐ Employee + spouse

☐ Employee + children ☐ Family

AUTHORIZATION FOR DEDUCTION

I ☐ agree ☐ do not agree to have the certificate documents delivered to the Policyholder electronically.

I elect the coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my Employer to deduct the contribution from my wages. I affirm, to the best of my knowledge and belief, that all information given by me on this form is true and complete. I have read or had read to me any Fraud notice below applicable to my state of issue of this enrollment form.

Enrollee's Signature:_____ **Date:**_____

REFUSAL/WAIVER – Complete ONLY if you are declining one or more offered coverages.

I have been offered insurance coverage as permitted by my Employer and decline to participate in the coverages not selected on the first page. I acknowledge that any coverage offered through my Employer not expressly selected on this application will be considered refused. I understand that in the event I desire such coverage at a later date, I may be required to furnish evidence of insurability satisfactory to Companion Life Insurance Company, at my own expense, and the Company shall have the right to refuse any request.

Enrollee's Signature:_____ **Date:**_____

NOTICE TO ENROLLEE – DETACH AND GIVE TO ENROLLEE

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.

Please See Pages 2 - 4 for Companion Life Insurance Company Fraud Notices

FRAUD NOTICE

General Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The fraud warnings listed below are applicable in the states of AL, AK, AZ, AR, CO, DE, DC, FL, ID, IN, KS, KY, LA, ME, MD, MA, MN, NH, NM, OH, OK, OR, PA, RI, TN, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and