GROUP SHORT TERM DISABILITY INCOME INSURANCE ENROLLMENT AND CHANGE REQUEST FORM

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

Underwritten by:
Companion Life Insurance Company
P.O. Box 100102| Columbia, S.C. 29202-3102
800-753-0404 (Phone)

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

□ New Employee □ Change Address □ Change Class or Status
□ Add/Increase Coverage □ Change Beneficiary □ Terminate Coverage

EMPLOYER INFORMATION – to be completed by the Employer or Group Administrator

Employer Name: _____

Group Number: _____ Dept/Div. Number: _____

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

Last Name (Include Jr., Sr., etc.)	First Name	M.I.
Street Address	City	State/Zip
Social Security Number	Home Telephone	Work Telephone Email Address

Male ☐ Female ☐	Marital Status □ Single □ Married	Annual Earnings $	Hours Worked Per Week
Occupation	Date of Birth: (MM-DD-YY) / /	Date Employed: (MM-DD-YY) / /	Coverage Effective Date: (MM-DD-YY) / /
Beneficiary (Last/First/MI)	Relationship		

Benefit Levels – Standard Option:
Select the Benefit Level (A - W) that meets your needs from the chart below and enter the Benefit Level letter in the box on the right.

Benefit Level	Weekly Benefit	Your Annual Salary must be at least	Benefit Level	Weekly Benefit	Your Annual Salary must be at least
A	$150	$11,700	T	$1100	$85,800
B	$200	$15,600	U	$1150	$89,700
C	$250	$19,500	V	$1200	$93,600
D	$300	$23,400	W	$1250	$97,500
E	$350	$27,300			
F	$400	$31,200			
G	$450	$35,100			
H	$500	$39,000			
I	$550	$42,900			
J	$600	$46,800	Max Level		
K	$650	$50,700			
L	$700	$54,600			
M	$750	$58,500			
N	$800	$62,400			
O	$850	$66,300			
P	$900	$70,200			
Q	$950	$74,100			
R	$1000	$78,000			
S	$1050	$81,900			

Benefit Level Selected

Weekly Benefits Will Equal The Amount Selected, Not To Exceed 66 2/3% Of Basic Weekly Earnings.

AUTHORIZATION

I have read and elect the short-term disability coverage selected for which I am eligible. The answers to the above questions are true and complete to the best of my knowledge and belief and I understand that the statement and answers above will be used by the insurance company to determine eligibility. 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.

Any person who knowingly presents a false statement of insurability for insurance may be guilty of a criminal offense and subject penalties under state law.

Proposed Insured's Signature:_____ **Date:**_____

Dated at (City & State):_____

REFUSAL/WAIVER – Complete ONLY if you are declining coverage.

I have been offered Short-Term Disability Insurance by my Employer 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 satisfactory to Companion Life Insurance Company, at my own expense, and the company shall have the right to refuse any request.

Proposed Insured's Signature:_____ **Date:**_____

Dated at (City & State):_____