Companion Life Insurance Company
P.O. Box 100102
Columbia, South Carolina 29202-3102
(803) 735-1251

Standard or High Option Employer Application

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

Application is made to Companion Life Insurance Company for a Dental Policy, the provisions of which shall be made available to all eligible classes of Employees.

General Information			
Group Medical Plan Effective Date/ Renewal Date:			
Group Medical Plan Number:			
Group Medical Plan Account Manager: Name: Phone Number:			
Dental Plan Effective Date (must be the same as Medical plan):			
Employer Group Information			
Group Name:		Tax Identification Number:	
☐ Corporation ☐ Proprietorship ☐ Partnership			
Group Legal Name (if different then above):			
Group Contact Name and Title:		Group Contact Email:	
Group Contact Phone:		Group Fax Number:	
Physical Address (P.O. Boxes are not allowed):			Suite Number:
City:	State:	ZIP Code:	County:
Mailing Address (if different from physical address):			Suite Number:
City:	State:	ZIP Code:	County:
Nature of Business:		SIC Code:	
Affiliates or subsidiaries to be covered Name:			
City:	State:	ZIP Code:	County:
Number of eligible employees residing outside of the state in which the policy was issued: State: Number of Employees:			

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Eligibility

CLASSES OF ELIGIBLE EMPLOYEES:

☐ Active employees - All active full-time employees (A full-time employee must work 30 hours per week of compensable time.)

☐ Other - Explain if there are any persons who will be enrolled who are not actively employed (i.e., retirees, COBRA, etc.):

NUMBER OF ELIGIBLE EMPLOYEES IN ELIGIBLE CLASSES **(minimum of 2 enrolled to qualify)**

A. Total number of employees on the payroll: _____

B. Less number of employees not eligible: _____

C. Total Number Enrolled: _____

DEPENDENT ELIGIBILITY

Spouse and/or children to age 26. If there are any additional eligibility requirements for dependents, please specify:

WAITING PERIOD

☐ Date of hire

☐ 1st of the month following date of hire

☐ 1st of the month following 30 days of employment

☐ 1st of the month following 60 days of employment

☐ Effective on the 91st date of employment (not eligible for 30-day orientation period)

☐ Group has a 30-day orientation period (waiting period begins after orientation period)

ELIGIBILITY

1. Part-time employment applies to waiting period? Yes ☐ No ☐
2. Does group agree to domestic partner coverage? Yes ☐ No ☐
3. Group is COBRA eligible? Yes ☐ No ☐
   If Yes, COBRA Administrator Name:

Employer Contributions

PERCENT OR AMOUNT

The Employer agrees to make the following contribution toward the cost of the employee and dependent coverage: Employee _____(% / $) Dependent _____(% / $)

Type of Coverage (select one)

Standard Option	High Option
☐ PPO-MAC Contributory (employer contributes)	☐ PRO PPO-MAC Contributory (employer contributes)
☐ PPO-MAC Voluntary (employee paid)	☐ PRO PPO-MAC Voluntary (employee paid)

Standard Option Premiums PPO-MAC		High Option Premiums PRO-PPO-MAC	
Employee	$26.18	Employee	$32.73
Employee + Spouse	$56.44	Employee + Spouse	$73.05
Employee + Child(ren)	$54.59	Employee + Child(ren)	$67.22
Employee + Family	$82.90	Employee + Family	$99.88

BenefitSource

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Signature

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 civil fines and criminal penalties.

AGREEMENT

A. This application is signed by a person or persons authorized by the Employer to make such an agreement; and

B. The application is received and approved by the Companion Life Insurance Company at its home office; and

C. The initial month's premium is received by Companion Life Insurance Company.

Coverage is effective on the first billing due date after the conditions in (a), (b), and (c) above have been met. Coverage is subject to all the terms and conditions of the Group Dental Policy.

SIGNATURES

For a corporation, the President or Vice President and the Secretary or Acting Secretary should sign. For a proprietorship, the owner should sign. For a partnership, any partner should sign. I have read this application, agreed to the terms, and certify that all statements are true and complete. It is understood that provisions of the Group Dental Policy, including premiums, therefore, may be amended or changed from time to time, upon written notice from Companion Life Insurance Company to the Employer.

Employer Representative	Agent/Broker
_____ (print name)	_____ (print name)
_____ (signature)	_____ (signature)
_____ Title	_____ Title
_____ Date	_____ Date