YORKTOWN ISD

Employer Paid and Supplemental Life and AD&D Insurance

Companion Life Insurance Company

Yorktown ISD provides each employee with $10,000 Basic Group Term Life insurance. There is no cost to the employee for the $10,000 life and AD&D insurance.

In addition to the employer provided insurance, employees may choose additional life insurance for themselves. Plus, supplemental insurance for dependent spouse and child(ren) is also available for employees to select.

The following costs are shown for each of the amounts up to the guarantee issue amount. If you desire amounts greater than $100,000 on yourself, the cost can be calculated using the formula listed Employee Amounts.

Supplemental Life and AD&D Insurance - Employee

You have the opportunity to enroll in Yorktown ISD's Supplemental Life and AD&D Insurance plan. Your election may be made by the benefit selections below. If you are a new hire the elections are guarantee issue up to 3 times salary, not to exceed $ 50,000. **Employees who have do not apply when first eligible must fill out the evidence of good health statement.** Use the benefit amount you select or select an amount of insurance as an example -- 50,000. Divide the amount by 1000, then multiply the result by $.23 to determine the cost. As an example, $50,000/1000 = 50 x .23 = $11.50 monthly cost. Please your choice from the table or your calculation on line below.

Benefit Amounts/Cost per month

20,000	40,000	50,000	60,000	70,000	80,000	90,000	100,000
4.60	9.20	11.50	13.80	16.10	18.40	20.70	23.00

_____ _____ _____ $_____ **A**

Your Monthly Cost*

*Note: Benefit reductions begin at age 65. Please see your benefits administrator for further information.

Supplemental Life and AD&D Insurance – Spouse

If you elect the Supplemental Life and AD&D plan for yourself, you may elect Supplemental Life coverage for your Spouse. Your election may be made by the benefit selections below, and it cannot exceed 50% of the amount you selected for yourself. If you are a new hire the elections are guarantee issue. Current employees have to fill out the evidence of good health. Choose between the 2 selections below. **Supplemental Spouse and premiums are based on the employee's age, not the Spouse's age.**

Check Box Below	Spouse Benefit Amount	Total Cost per Month
	10,000	$2.00
	20,000	$4.00
	30,000	$6.00
	40,000	$8.00
	50,000	$10.00

Spouse $_____ **B**

Supplemental Life and AD&D Insurance – Child(ren)

If you elect the Supplemental Life and AD&D plan for yourself, you may elect Supplemental Life coverage for your child(ern). Your election may be made by the benefit selections below, and it cannot exceed 50% of the amount you selected for yourself. If you are a new hire the elections are guarantee issue. Current employees have to fill out the evidence of good health.

Check Box Below	Spouse Benefit Amount	Total Cost per Month
	5,000	$0.80

Child(ren) Cost $_____ **C**

Employee Confirmation

I have been given the opportunity to enroll in Yorktown ISD Group Supplemental Life and AD&D Insurance plans. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Companion Life Insurance Company and understand my request for coverage may be denied.

GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST

Companion Life

Companion Life Insurance Company
P.O. Box 100102 • Columbia, S.C. 29202-3102
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	Group No. (10 digit #)	DEPT/DIV (3 digit #)	CLASS
Name of Employer (Use Name from Group Billing Notice or Master Application)			

TO BE COMPLETED BY EMPLOYEES

Social Security Number	Effective Date	Date Employed Full-time	Date of Birth	Hours Worked Per Week
	Month / Day / Year	Month / Day / Year	Month / Day / Year	

Your Name — Last / First / M.I.

Sex: ☐ Female ☐ Male

☐ Weekly ☐ Monthly ☐ Annually
Earnings $ _____ *
**Do not include overtime or bonuses*

Marital Status: ☐ Single ☐ Married

Occupation

Your Home Address — Street / Apt/Suite No. / City / State / ZIP Code

COMPLETE FOR LIFE AND/OR DISABILITY

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

COMPLETE FOR VOLUNTARY LIFE

Amount Selected:
EMPLOYEE: Voluntary Life $ _____ **SPOUSE:** Voluntary Life $ _____ **CHILD:** Voluntary Life $ _____

Spouse Name: *(Voluntary Life Only)* Last / First / M.I.	Birthdate (M/D/Y)	Social Security Number

Beneficiary for Employee Coverage/Relationship: *(Employee is beneficiary for dependent coverage) (Applies to Life, Disability and Critical Illness)*
Last / First / M.I. / Relationship to Insured

COMPLETE FOR DENTAL AND/OR VISION AND/OR CRITICAL ILLNESS

Coverage Requested:
☐ Dental- Employee Only ☐ Dental - Employee & Dependents
☐ Vision - Employee Only ☐ Vision - Employee & Dependents
☐ Critical Illness - Employee Only ☐ Critical Illness - Employee & Dependents

Is your spouse to be covered? ☐ Yes ☐ No

Dental and/or Vision Coverage Is For (Check Box Below):
☐ Employee ☐ Employee plus Spouse ☐ Employee plus Child(ren) ☐ Family

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

Complete for Dependent Coverage — Spouse Name (Last / First / M.I.)	Date of Birth M / D / Y	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 ☐ Short Term Disability ☐ Long Term Disability ☐ Dental ☐ Vision ☐ Critical Illness ☐ Voluntary Life ☐ Voluntary Long Term Disability ☐ Voluntary Dental

Date	Your Signature
	X

95206 Rev. 1/19

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, TX, VT, VA, WA, and WV. Please review the appropriate fraud warning relevant to the state that you reside in prior to submitting your claim.

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NOTICE TO PROPOSED INSURED – DETACH AND GIVE TO PROPOSED INSURED

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.

Companion Life
Companion Life Insurance Company
P.O. Box 100102 • Columbia, S.C. 29202 • (803) 735-1251

GROUP INSURANCE HEALTH STATEMENT

You must provide the following health information to obtain the requested insurance coverage if:

(1) You are required by Companion Life to furnish evidence of insurability; (2) you previously declined or terminated coverage; or (3) (For Life, STD, LTD) your application for coverage is being made more than 31 days after you originally became eligible for this coverage. Please answer every question and complete every space. **Complete for spouse and child(ren) (if applicable) if applying for Voluntary Life Insurance Coverage.**

Name and address of the Doctor or facility that has your medical records.

Employee's Doctor: _____ Spouse's Doctor: _____ Child's Doctor: _____

Address: _____ Address: _____ Address: _____

Employee: Height: _____ Weight: _____
Have you gained or lost more than 20 pounds in the last year?
☐ Yes ☐ No
If yes, amount ☐ gained or ☐ lost: _____ pounds
(Explain below.)

Spouse: Height: _____ Weight: _____
Have you gained or lost more than 20 pounds in the last year?
☐ Yes ☐ No
If yes, amount ☐ gained or ☐ lost: _____ pounds
(Explain below.)

Check *yes* or *no* for each of these questions and give details for any "yes" answers. Attach a separate sheet if more space is required.

	EMPLOYEE		SPOUSE		CHILD	
	Yes	No	Yes	No	Yes	No
1. Has proposed Insured:						
a. Ever had an application for life or health insurance, or for reinstatement thereof, declined or modified?	☐	☐	☐	☐	☐	☐
b. Ever applied for or received any disability compensation?	☐	☐	☐	☐	☐	☐
c. Smoked cigarettes in the past 12 months?	☐	☐	☐	☐	☐	☐
d. Flown or intended to fly as a pilot, student pilot or crew member?	☐	☐	☐	☐	☐	☐
2. Are you now actively employed on a full time basis (30 hours or more per week)?	☐	☐	☐	☐	☐	☐
3. To the best of your knowledge and belief, do you have any physical impairment or disease?	☐	☐	☐	☐	☐	☐
4. Within the past 10 years, have you been diagnosed by a member of the medical profession as having, or been treated by a member of the medical profession for:						
a. Coronary artery disease, abnormal blood pressure, diabetes or cancer?	☐	☐	☐	☐	☐	☐
b. Disorder of the respiratory, cardiovascular, hematological, endocrine or metabolic, gastrointestinal, genito-urinary or nervous system?	☐	☐	☐	☐	☐	☐
c. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or have you tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐
d. Drug or alcohol dependency or abuse?	☐	☐	☐	☐	☐	☐
5. Do you have any other abnormality, deformity, disease or disorder not recorded above, including accidents?	☐	☐	☐	☐	☐	☐
6. Have you ever been a patient in a hospital, sanitarium, or institution?	☐	☐	☐	☐	☐	☐
7. Have you been absent for a period of 5 or more consecutive days during the last two years due to sickness or injury?	☐	☐	☐	☐	☐	☐
8. Have you ever had any surgical operations or had surgery advised but not performed?	☐	☐	☐	☐	☐	☐
9. To the best of your knowledge and belief, are you now pregnant?	☐	☐	☐	☐	☐	☐

10. Give the name and address of your personal physician and the date and reason for your last consultation.
Name: _____ Address: _____ Date: _____ Reason: _____

11. Details in connection with questions **3-8** answered "YES" above.

Question No.	Name	Date Mo. Yr.	Give Full Details for Each Question Answered "Yes" Including Nature of Illness or Injury, Number of Attacks, Duration, Severity, Treatment, Results and any Other Pertinent Information	Name and Address of Physician or Hospital

I have _____ (number) children eligible as defined in the group policy.

All eligible children are free of any sickness, disease or injury, as defined in Questions 3 through 9 above, except as follows (Write "none" if all children do not need treatment or are free of impairments.): _____

I hereby certify that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning any proposed insured's past or present health has been omitted. I agree that such answers will form a part of my application for group insurance and that such insurance will not become effective until such application has been approved by Companion Life Insurance Company.

MEDICAL AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, Medicare Part A and Part B carrier, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me, my spouse and all dependent children proposed for coverage, or our health, to give Companion Life Insurance Company or their reinsurers any such information. I understand that Companion Life Insurance Company will collect this information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Companion Life Insurance Company, P.O. Box 100102, Columbia, SC 29202. I understand that revocation may be a basis for denying insurance benefits or a claim for benefits. I understand that if I fail to sign this authorization Companion Life may not be able to evaluate or process my application or claim and may be a basis for denying my application or claim for benefits. I know that I have a right to receive a copy of this authorization upon request. A photostatic copy of this authorization shall be valid as the original.

Witness _____ Date _____ _____ Date _____

Signature of Proposed Insured (or, if below age 15, parent or guardian)