



# GROUP DENTAL INSURANCE ENROLLMENT FORM AND CHANGE REQUEST

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

PLEASE COMPLETE IN INK and return to Advantage RN.

- New Employee       Change Beneficiary       Change Address       Change Class or Status
- Add/Increase Coverage       COBRA       Change Dependent Coverage       Terminate Coverage

## SECTION A. TO BE COMPLETED BY EMPLOYER

Name of Employer <b>Advantage RN</b>	Group No. (13 digit #) <b>9021405889000</b>	DEPT/DIV	CLASS
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## SECTION B. TO BE COMPLETED BY EMPLOYEES

Your Name: Last	First, M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually    (Do not include overtime of bonuses)	Earnings: \$ _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married		Occupation: _____		
Your Home Address		City	State	Zip Code
Social Security Number	Date of Birth / /	Effective Date / /	Date Employed Full Time / /	Hours Worked Per Week

## SECTION C. COMPLETE FOR DENTAL

Is your spouse to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental Coverage is for (Check Box):	
<input type="checkbox"/> Employee	<input type="checkbox"/> Employee plus 1 [ <input type="checkbox"/> Spouse or <input type="checkbox"/> Child ]
<input type="checkbox"/> Employee plus 2	<input type="checkbox"/> Employee plus 3 or more [ <input type="checkbox"/> Spouse <input type="checkbox"/> Child or <input type="checkbox"/> 2 Children ]

## SECTION D. COMPLETE FOR DEPENDENT COVERAGE

	Spouse Name: Last	First, M.I.	Student	Date of Birth	Sex	Do any of your dependents have any other dental coverage? If Yes, Name of Carrier:
			<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
CHILDREN	1		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION E. 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:  Dental      Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

**FRAUD WARNING (Not Applicable in AZ, FL, GA, MD OR, VA):** Any person who knowingly and with intent to defraud any insurance company of other person files an application for insurance or 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.

**FRAUD WARNING (FL only):** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I elect the above coverage which I have checked from those for which I am eligible, and I decline the above coverage which I have not checked from those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorized my employer to deduct the contribution from my wages.

In regards to the section entitled COMPLETE FOR DENTAL, the following statement applies: "The policy provides dental benefits only. Review your certificate carefully."

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

----- **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.