PLAN ADMINISTRATION, LTD GROUP ENROLLMENT CARD	Group Policy No.	Cert No.	Social Security (Cert) No.

APPLICANTS Last Name (Please Print)	First Name	Initial	State	Class	SEX M F

APPLICANTS RESIDENCE	Street Address	City	State	Zip

Name of Employer, Association or Union	Location

Salary $ Hrs. Worked	Union Non-Union	Date of Birth Mo. Day Year	Occupation	Title

Date Employed Full Time Mo. Day Year	Date Eligible Mo. Day Year	Life & AD&D
		GA ALL

Other Spouse Benefits	A&S	LTD	Dependent	Sup\Vol
		0560		

BENEFICIARY DESIGNATION (Please Print)	First Name	Initial	Last Name	Relationship

I (1) REQUEST THE GROUP INSURANCE COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE (2) AUTHORIZE DEDUCTIONS FROM MY PAY OR DUES FOR MY SHARE OF THE COST, IF ANY, AND (3) DESIGNATE THE BENEFICIARY NAMED ON THIS CARD TO RECEIVE THE PROCEEDS; IF ANY, PAYABLE IF I DIE.

Decatur County Board of Education Bainbridge, Georgia

Date Signed

X

Applicants Signature

N/A

Decatur County BOE - Long Term Disability

N/A YES N/A N/A

Complete the above LTD Form with your information and sign at the bottom.

Please place your SS#, Name, State, Sex, Address, D/O/B, Occupation, Title, Full Time Employment, Beneficiary & Sign Form

If you are adding coverage during open enrollment, complete the below attached EOI Form

Companion Life

Companion Life Insurance Company

Return form to: Plan Administration
580 Hazard Avenue, Enfield, CT 06082
Ph: 860-272-1135 Fax: 860-272-1136

HEALTH STATEMENT

Employee's Name: _____ Employee's SSN: _____

Employee's Date of Birth: _____ Group Name: _____ Group #: _____

Employee's Address: _____

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: _____ Address: _____

Spouse's Doctor: _____ Address: _____

Child's Doctor: _____ 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** Yes	No	**SPOUSE** Yes	No	**CHILD** Yes	No
1. Within the past 10 years has the proposed Insured:						
a. Had an application for life or health insurance, or for reinstatement thereof, declined or modified?	☐	☐	☐	☐	☐	☐
b. Applied for or received any disability compensation?	☐	☐	☐	☐	☐	☐
c. Flown or intended to fly as a pilot, student pilot or crew member?	☐	☐	☐	☐	☐	☐
2. Has the proposed Insured used tobacco products in the past 12 months?	☐	☐	☐	☐	☐	☐
3. Are you now actively employed on a full-time basis (30 hours or more per week)?	☐	☐	☐	☐	☐	☐
4. To the best of your knowledge and belief, do you have any physical impairment or disease?	☐	☐	☐	☐	☐	☐
5. 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) or any other immune deficiency disorder?	☐	☐	☐	☐	☐	☐
d. Drug or alcohol dependency or abuse?	☐	☐	☐	☐	☐	☐
e. Have you been diagnosed with, treated for (including any prescription medications) or lost time from work due to any condition relating to the following: Bone, Joint, Spine, Muscle or Connective Tissue?	☐	☐	☐	☐	☐	☐
6. Do you have any other abnormality, deformity, disease or disorder not recorded above, including accidents?	☐	☐	☐	☐	☐	☐
7. Have you ever been a patient in a hospital, mental health facility, or institution?	☐	☐	☐	☐	☐	☐
8. Have you been absent for a period of 5 or more consecutive days during the last two years due to sickness or injury?	☐	☐	☐	☐	☐	☐
9. Have you ever had any surgical operations or had surgery advised but not performed?	☐	☐	☐	☐	☐	☐
10. To the best of your knowledge and belief, are you now pregnant?	☐	☐	☐	☐	☐	☐

(Continued on back)

(Continued)

11. Give the name and address of your personal physician and the date and reason for your last consultation.

Name: _____ Address: _____ Date: _____

Reason: _____

List details in connection with questions 4-10 that were answered "YES" on page 1:

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, Including Prognosis.	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 4 through 10 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, that no material information concerning any proposed insured's past or present health has been omitted, and that the statements in this application are representations and not warranties. 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 and Medicare Part A and Part B carrier 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)

Companion Life®

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