COMPANION LIFE INSURANCE COMPANY
APPLICATION/ENROLLMENT FORM FOR INSURANCE

APPLICANT INFORMATION

Applicant's Name _____ **Social Security Number** _____
Last/First/MI

Home Address _____
Street City State Zip

Home Telephone _____ **Work Telephone** _____

Sex: ☐ Male ☐ Female **Date of Birth** _____

Requested Effective Date (First of the Month only) _____

Plan Selected: ☐ PLAN I ☐ PLAN II ☐ PLAN III **Initial Premium: $** _____

DEPENDENT INFORMATION

Dependent Name Last/First/MI	Date of Birth Mo/Day/Yr	Relationship	Social Security No.

Please answer the following question completely and accurately. (A **"YES"** answer means coverage cannot be issued.)

Is the Applicant, the Applicant's spouse or Applicant's dependents (whether applying for coverage or not) now pregnant and/or in the process of adopting a child? ☐ Yes ☐ No

APPLICANT AUTHORIZATION

DO NOT CANCEL OTHER COVERAGE UNTIL NOTIFIED IN WRITING BY THE INSURANCE COMPANY OF ACCEPTANCE OF THIS APPLICATION

I certify that all answers contained herein are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the risk or hazard assumed by the Insurance Company may bar the right to any recovery under any Certificate issued. I understand that no coverage will become effective under the Certificate until written approval is received from the Insurance Company. I understand that no benefits will be payable for expenses incurred as a result of a Pre-Existing Condition (as defined in the policy) until the earlier of: (a) the end of a continuous period of 12 months commencing on or after the Covered Person's effective date of coverage under the Certificate during all of which the Covered Person has received no medical advice or treatment in connection with such Pre-Existing Condition; or (b) coverage has been in effect under this plan for 24 consecutive months. I have read any Fraud notice applicable to my state of residence on the reverse side of this application. I AUTHORIZE [USA SAVERS ASSOCIATION] TO COLLECT ANY AND ALL PREMIUMS DUE UNDER THE POLICY.

_____ _____
Applicant Signature Date

AGENT'S STATEMENT

I, the undersigned, certify that I am currently licensed as an accident & health agent in the resident state of the applicant. I certify that the information contained herein is correct to the best of my knowledge. I have advised the applicant that this coverage is not intended to replace major medical coverage and not to terminate any existing coverage until receiving notice that the certificate being applied for by this application is approved in writing. I understand that I have no right to bind this coverage, to alter the terms of the policy or certificate in any manner, or to adjust any claim for benefits under the policy or certificate.

_____ _____
Signature of Agent Date

PO BOX 47 NEW HAVEN MO 63068 573-237-2978
Address MHP 001A013 City/State/Zip 573-237-3776 Telephone #

BOBF@fidnet.com
G A Agent License # Fax # E-Mail Address

AGENTS NUMBER _____

MMA 2272