



PART I: TO BE COMPLETED BY POLICYHOLDER (Please Print)

Group Number _____ Group Name and Address _____ Group Contact _____ (Print Name) Group Contact _____ (Print Title) Telephone (____) _____	FOR FDL USE ONLY	
	EMPLOYEE <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Cancelled <input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker	SPOUSE <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Cancelled <input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker
	GI <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____	GI <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
	AMOUNT APPROVED \$ _____ Eff. Date _____	AMOUNT APPROVED \$ _____ Eff. Date _____
	Reviewed by _____ Date _____	Reviewed by _____ Date _____
	CHILD(REN) <input type="checkbox"/> Approved <input type="checkbox"/> Declined Eff. Date: _____	State Code _____ Agency (CB)(TPA) _____
	New Hire Waiting Period _____	<input type="checkbox"/> Self-Admin <input type="checkbox"/> Direct Bill _____

PART II: TO BE COMPLETED BY EMPLOYEE Voluntary Life Amount over Guarantee Issue Late Enrollment

Employee Name	Last	First	M.I.	Date of Birth	Age	Sex	State of Birth
				/ /		<input type="checkbox"/> M <input type="checkbox"/> F	
Home Mailing Address - Street			City	State	Zip	Work Telephone	Home Telephone
				()	()	()	()
Social Security #	Employee Height _____ ft. _____ in. Weight _____ lbs.			Spouse/Dep. Height _____ ft. _____ in. Weight _____ lbs.			
Spouse/Dep.	Last	First	M.I.	Social Security #	Date of Birth	Age	State of Birth
					/ /		

PART III: INSURABILITY QUESTIONNAIRE (Underline condition & record details in PART IV.)

	Employee	Spouse/Dep.
1. Have you used cigarettes or other tobacco products in the last 2 years?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Within the past 5 years, have you been medically counselled or treated for, or been told by a medical practitioner that you had: heart murmur; high blood pressure; heart attack; any disease of the heart or blood vessels; diabetes; albumin; blood or sugar in urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disease of the stomach, liver or intestines; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Within the past 5 years have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or ARC (AIDS Related Complex) or any other immunological disorders?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Within the past 5 years have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Are you presently receiving any treatment by a medical practitioner or taking any medication?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Have you ever been rated, declined, postponed or limited in any way for life, health, accident or sickness insurance?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

PART IV: Provide details of all 'YES' answers given to questions in PART III. – If additional space is required, attach a separate signed and dated sheet.

Question # & Individual	Illness/Reason for Checkup or Doctor's Treatment/Consultation	Dates From To	Full Name, Complete Address and Telephone # of Attending Physician or Other Practitioner

YOU MUST COMPLETE BOTH PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.



Employee Name _____ Social Security # _____

WARNING: Any person who knowingly and with intent to defraud any insurance company or 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 a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in Oregon or Virginia.)

AGREEMENTS AND AUTHORIZATION: I, the undersigned applicant(s), have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Fort Dearborn Life Insurance Company (FDL) shall not be liable for any claim arising prior to the date of approval of this application at FDL's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, medical facility, medical provider, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, (HIV) Human Immunodeficiency Virus or other sexually transmitted diseases.

I further authorize FDL to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB Group, Inc. a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- Coverage will not become effective until FDL approves my application, provided that I am actively at work on that day.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from FDL.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

 Signature of Employee

 Date

 Signature of Spouse (if requesting insurance)

 Date

 Signature of Dependent Child (if to be insured and of age of majority)

 Date



(Please retain with your insurance records)

Thank you for enrolling for Group Insurance with Fort Dearborn Life Insurance Company. To assist us in processing the group policy, your signature on the Agreements and Authorization section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Fort Dearborn Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization, of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply each company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston MA 02112, telephone number 866-692-6901 (TTY 866-346-3642).

Fort Dearborn Life Insurance Company, its reinsurers, or designated representative(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



EMPLOYER: If group is self-administered, submit enrollment form **only** if evidence of insurability is required. If group is not self administered, submit enrollment form to us.

EMPLOYEE NAME — LAST		FIRST	MIDDLE INITIAL	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)		EARNINGS \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual		JOB TITLE		CLASS
EMPLOYER			GROUP NO./ACCOUNT NO. /		LOCATION	

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. **Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

BASIC COVERAGE(S)				Supplemental Life	Supplemental AD&D	Other _____
Basic Life/AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO	STD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	LTD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	Dependent Life <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del. \$ _____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del. \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____

VOLUNTARY COVERAGE(S) (Evidence of Insurability may be required on employee and spouse Life and Critical Illness Insurance)	(A)dd (C)hange (D)elete	Total Amount of Coverage Applied for	If (C), my prior coverage was
Voluntary Term Life: Employee <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Term Life: Spouse <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Term Life: Dependent Child(ren) <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary AD&D: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> NO			
Voluntary Short-Term Disability <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Long-Term Disability - Incremental <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Long-Term Disability - % of Salary <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Critical Illness with Cancer Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Critical Illness without Cancer Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO			

SPOUSE NAME — LAST (if applicant)	FIRST	M.I.	SEX M <input type="checkbox"/> F <input type="checkbox"/>	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #
Has Employee (if applicant) used cigarettes or other tobacco products in the last 2 years? <input type="checkbox"/> YES <input type="checkbox"/> NO			Has Spouse (if applicant) used cigarettes or other tobacco products in the last 2 years? <input type="checkbox"/> YES <input type="checkbox"/> NO		

*** Review the following guidelines which apply to voluntary coverage(s)**

- You may enroll, apply for additional coverage, or request a change to current voluntary benefits only during a scheduled enrollment period.
- Your weekly STD benefit may not exceed 60% of your basic weekly earnings (excluding bonuses, overtime and any extra compensation other than commissions).
- If you are eligible for state-mandated temporary disability benefits, or any employer sponsored income replacement benefits, the combination of your state mandated benefit or other income benefit and your STD weekly benefit may not exceed 60% of your basic weekly earnings.
- New Voluntary STD plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA).
- Your Voluntary LTD benefit for incremental plans may not exceed 60% of your basic earnings (excluding bonuses, overtime and any extra compensation other than commissions).
- New Voluntary LTD plans and benefit increases are subject to a pre-existing condition limitation. Your certificate of coverage will fully explain this limitation.
- If your earnings are based in whole or in part on commissions, commissions will be averaged over the 12-month period prior to the date disability begins.

BENEFICIARY DESIGNATION (For Employee Only: Must Be Completed if you have applied for life or AD&D insurance) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY #	BENEFIT %
Primary					%
Primary					%
Contingent					%

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK AS DEFINED IN THE POLICY ON THE DATE MY COVERAGE WOULD OTHERWISE BECOME EFFECTIVE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I MEET THE POLICY DEFINITION OF ACTIVELY AT WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

Any person who knowingly and with intent to defraud any insurance company or 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 a fraudulent insurance act which is a crime and may subject such person to criminal and civil penalties.

EMPLOYEE SIGNATURE _____ DATE ____/____/____

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