

If your Insurance benefit terminates, you are eligible to continue your Voluntary Life, Voluntary Dependent Life and Critical Illness coverage. Except for the Additional Purchase Option, this can be done at the rate for your attained age indicated on the back, regardless of your physical condition. The Additional Purchase Option requires satisfactory evidence of insurability if your employer's group policy effective date is 4/1/03 or later. You must apply for the continuation within 31 days of the date of termination of coverage. For information about the maximum amount you may continue, see your certificate.

To apply:

1. Complete Part 2 of this application for portability. Be sure that your employer has completed Part 1. Premium rates and instructions for figuring your premium are shown on the back of this form.
2. Mail completed application **together with your check or money order** for the first modal premium within 31 days of termination of coverage to the address indicated on the back.

Part 1 TO BE COMPLETED BY EMPLOYER (A copy of original approved Evidence of Insurability must be submitted with this application)

Group Number		Name of Employer		Insurance Class for Basic Life Coverage:	
Date Employment Terminated	Date Coverage Terminated	Last Day of Actual Work		Annual Salary for Basic Life Coverage (if salary based)	
Does Employee have: Voluntary Life?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____	Signature of Person Authorized to Certify for Group	
Voluntary Dependent Life?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Critical Illness Benefit with Cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____		
Critical Illness Benefit without Cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____		
Does Spouse have: Voluntary Life?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____		
Voluntary Dependent Life?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Critical Illness Benefit with Cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____		
Critical Illness Benefit without Cancer?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____		
What rate is the Insured currently paying?		<input type="checkbox"/> Tobacco <input type="checkbox"/> Non-Tobacco		Date	
What rate is the Spouse currently paying?		<input type="checkbox"/> Tobacco <input type="checkbox"/> Non-Tobacco			

Part 2 TO BE COMPLETED BY INSURED Please type or print with ball point pen

In accordance with and subject to all the terms and conditions of the portability provision contained in my certificate, I elect to continue my coverage under the Group Policy and agree to pay for the coverage(s) indicated below.

Name in Full		Social Security Number	Sex	Telephone Number ()
Street Address		City	State	Zip Code
Date of Birth	Last Date of Active Work	Spouse Name	Spouse Sex	Spouse Date of Birth

I wish to continue:	Employee	Spouse
<input type="checkbox"/> Voluntary Life	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____
<input type="checkbox"/> I wish to exercise the Voluntary Life Additional Purchase Option	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____	
<input type="checkbox"/> Voluntary Critical Illness Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____
<input type="checkbox"/> Voluntary Dependent Life	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount \$ _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Beneficiary Designation	First Name	Last Name	Date of Birth	Social Security Number	Relationship	Benefit %
(Primary)			/ /			%
(Primary)			/ /			%
(Contingent)			/ /			%
(Contingent)			/ /			%

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 be 100%.

Billing Mode (Select one) Quarterly Semi-Annual Annual

I have read the above questions and answers and hereby declare that they are complete and true to the best of my knowledge and belief. I further agree that while my eligibility to continue this coverage under the terms of the Group Insurance Policy is being determined, the company may deposit the payment submitted with this application. If I am not eligible to continue my Voluntary Group Insurance, the sole obligation of the company shall be to refund the above payment.

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.

Employee Signature _____ Date _____ Spouse Signature _____ Date _____

Portability Premium Calculation Worksheet

You may continue an amount up to the full amount of your Voluntary Term Life benefit without evidence of insurability. Subject to satisfactory evidence of insurability under the Additional Purchase Option, if the group policy effective date is 4/1/03 or later, you may continue up to \$50,000 of your Basic Group Term Life benefit. You may continue an amount up to the full amount of your Critical Illness Benefit. To calculate your premium find the applicant's attained age and the corresponding basic quarterly premium per \$1,000 from the columns below. **If you and/or your spouse have used cigarette or tobacco products within the last two years, the tobacco rates should be used in calculating the first modal premium.** Multiply this premium by the number of thousands of dollars of insurance you plan to continue.

Voluntary Life Rates Quarterly Premiums (per \$1,000)

Attained Age	Non-Tobacco	Tobacco
Under 30	.45	.87
30-34	.51	.93
35-39	.72	1.26
40-44	1.23	2.01
45-49	1.71	3.75
50-54	2.85	6.09
55-59	4.95	11.01
60-64	7.77	13.44

Coverage terminates at age 65 for groups with effective dates of 9/1/08 or later.

Attained Age	Non-Tobacco	Tobacco
65-69	12.27	21.63

Coverage terminates at age 70 for groups with effective dates between 4/1/03-8/31/08.

Group policyholder effective date prior to 4/1/03

70-74	19.65	34.50
75 and Over	34.80	57.90

Voluntary Dependent Life Rates per Family per Quarter:

\$5,000 Benefit - Family \$3.00
 \$10,000 Benefit- Family \$6.00

Critical Illness Benefit with Cancer Rates Quarterly Premiums (per \$1,000)

Attained Age	Non-Tobacco	Tobacco
20-24	\$.69	\$ 1.32
25-29	.93	1.80
30-34	1.17	2.37
35-39	1.59	3.42
40-44	2.49	5.55
45-49	3.87	8.67
50-54	5.79	13.14
55-59	8.37	18.93
60-64	12.15	28.92

Critical Illness Benefit without Cancer Rates Quarterly Premiums (per \$1,000)

Attained Age	Non-Tobacco	Tobacco
20-24	\$.30	\$.42
25-29	.45	.63
30-34	.60	.90
35-39	.78	1.23
40-44	1.29	2.10
45-49	2.31	3.81
50-54	3.60	6.12
55-59	5.52	9.48
60-64	7.56	13.20

Critical Illness Portability not available beyond age 64.

Example

Employee wants to exercise the Portability Option and continue his Voluntary Term Life Insurance for \$100,000, his spouse's Voluntary Term Life Insurance of \$10,000 and his Voluntary Dependent Life. The employee is 54 years old and his spouse is 49 and they are both non-tobacco users. The employee wants to be billed quarterly.

Employee	\$2.85	X	100,(000)	=	\$285.00
Spouse	\$1.71	X	10,(000)	=	17.10
Voluntary Dependent Life			5,000	=	3.00
Total premium due each quarter					\$305.10

Your Calculations

	Table Rate X		# Thousands of Coverage	=	Quarterly Premium
Employee _____	X	_____	=	_____	
Spouse _____	X	_____	=	_____	
Voluntary Dependent Life _____		_____	=	_____	

Mail to: Fort Dearborn Life Insurance Company
 20445 Emerald Parkway, Suite 400
 Cleveland, Ohio 44135

Questions: 1-800-544-9000