FORT DEARBORN LIFE
Insurance Company®
Chicago, Illinois

Application for Group Insurance

Administrative Offices: Downers Grove, Illinois | Dallas, Texas

❑ New Application ❑ Change*	*To add benefits or change your group insurance program, complete the items in Sections 1 and 2 marked with an *, and Section 3.	**Group #:** ______________

Section 1. APPLICANT INFORMATION Please Type Or Print All Information

*Policyholder (correct legal name) ______________________________ EIN#____________

Address ____

City ______________________________ State ________________ ZIP ___________

*Phone ( ) ______________________________ *Fax ( ) ______________________________

*Group Contact ____

*Email Address ____

Check if applicable: ❑ Partnership ❑ Subchapter S Corp. ❑ Sole Proprietorship ❑ Corporation

Subsidiaries, Affiliates or Divisions to be covered? ❑ Yes ❑ No (If more than one, indicate on separate sheet.)

If Yes: Company Name ____

Address ____

Will they be billed separately? ❑ Yes ❑ No (If separate bills are desired, list address of subsidiaries or affliates on a separate sheet.)

Nature of Business	# Years in Business	SIC Code	Effective Date 12:01 a.m.	First Anniversary

*Annual Enrollment Period for Contributory Coverages, if applicable: from _____/________ to _____/________	**FICA TAX/W-2 Information:** A FICA Tax/W-2 Agreement must be completed and attached to this Application for all groups with Disability coverage.

Section 2. GENERAL INFORMATION

***Product Choice** (check all that apply)	***Employer will contribute**	***Total Eligible**	***Total Enrolled**	**Initial Rate Guarantee**
❑ Group Term Life & AD&D	❑ 100% ❑ Other _____%			_____ months
❑ Group Dependent Term Life	❑ 100% ❑ Other _____%			_____ months
❑ Group Short-Term Disability (STD)	❑ 100% ❑ Other _____%			_____ months
❑ Group Long-Term Disability	❑ 100% ❑ Other _____%			_____ months
❑ Supplemental Term Life & AD&D	❑ 0% ❑ Other _____%			_____ months
❑ Voluntary Term Life	❑ 0% ❑ Other _____%			_____ months
❑ Voluntary Term Life & AD&D	❑ 0% ❑ Other _____%			_____ months
❑ Voluntary Short-Term Disability 50+ (VSTD)	❑ 0% ❑ Other _____%			_____ months
❑ Vol. Short-Term Disability Income Protection (VSTD)	❑ 0% ❑ Other _____%			_____ months
❑ Voluntary Long-Term Disability 50+ (VLTD)	❑ 0% ❑ Other _____%			_____ months
❑ Vol. Long-Term Disability Income Protection (VLTD)	❑ 0% ❑ Other _____%			_____ months

Eligibility Waiting Period for:
❑ All employees ❑ New employees only

❑ None
❑ First of month following completion of ________ days
❑ Premium due date following _________ days
❑ Other ______________________________

Premium Payable on the ____________ day of each

❑ Month
❑ Quarter
❑ 12 Month
❑ Other _______

Section 3: AUTHORIZATIONS

The undersigned employer and/or authorized representative hereby request that it be approved for insurance coverage through Fort Dearborn Life Insurance Company (FDL). The employer agrees to payment of the required premiums if approved for coverage. The undersigned understands, represents to the best of his knowledge, believes and certifies to:

1. Comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the FDL trust policy(ies), if applicable;
2. Make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. Maintain records and furnish FDL or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. Provide notice of life insurance conversion rights to eligible employees and eligible dependents;
5. Pay FDL by the premium due date, the premiums on behalf of each employee covered under the contract, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;

Further the undersigned agrees that:

6. Claims filed by or on behalf of employees may, at FDL's option, be suspended if premiums are not received timely;
7. The premium deposit does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on FDL's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of FDL except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
8. In order for FDL to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, FDL, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application;
9. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to FDL by the employer. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the group's coverage or premium rate as of the effective date of coverage;
10. The entire application for Group Insurance has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief;
11. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, and meet all eligibility requirements for coverage;
12. Eligibility requirements include (a) working in the United States of America for the Policyholder or Employer (b) for at least the number of hours set forth in the Class Descriptions of the proposal and (c) completion of the Eligibility Waiting Period. Part-time, seasonal and temporary employees are not eligible.
13. The requested coverage is not in effect unless and until this application is approved by FDL, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, or other notification that risk has been accepted, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by FDL. The employer agrees that it will not collect any premium from employees requiring medical underwriting until notified of the approval of the employee's application for coverage.
14. It is understood and agreed that this application shall be made part of the Policy for which application is made. I have relied upon no oral or written representations that contradict item (16) below.
15. STD coverage, if elected, is not in lieu of and does not satisfy an employer's obligation to provide coverage under any state compulsory disability benefit act or law.
16. Being Actively at Work is a requirement for coverage. If an employee is not Actively at Work on the day his coverage would otherwise be effective, the effective date of his coverage will be the date of his return to Active Work. If an employee does not return to Active Work, he will not be covered. The terms "Actively at Work" and "Active Work" mean that an employee is performing the normal duties of his occupation, is working the number of hours specified in the Schedule of Benefits section of the proposal and satisfies any other conditions required by the applicable group Policy.

Authorized Signature	Date
Title	Licensed Resident Agent (if required)

Broker Certification: I hereby certify that: (1) I have reviewed the attached employee enrollment forms and group applications for completeness and accuracy. (2) I am not aware of any health history of any applicant that does not appear on the enrollment form. (3) I have not completed any of the information contained in the enrollment form except with permission of the applicant and as noted by my initials on the enrollment form. (4) I have not signed any of the enrollment forms for a group representative or individual applicant. (5) I have fully explained to the Employer that an employee not actively at work on the policy effective date or their eligibility date will not be covered until such employee returns to active work full-time. (6) I have explained that no premium should be collected from or on behalf of any employee requiring medical underwriting prior to approval of the employee's application by the Insurer. (7) I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or a re-rating of the group's premium retroactive to the effective date of coverage, and that coverage shall not be effective until FDL reviews and approves the application and the group receives a written notice and contract from FDL. (8) I am licensed in the state of this group for the types of insurance solicited.

Print Name	Signature	Date

The laws of some states require us to furnish you with the following notice:

FOR APPLICATIONS AND CLAIMS:

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: 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.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine & Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Maryland: Any person who knowingly and willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowingly that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands and Guam.

The laws of some states require us to furnish you with the following notice:

FOR CLAIMS ONLY:

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR APPLICATIONS ONLY:

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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Dearborn National™

FICA Tax/W-2 Agreement

Administrative Offices: Downers Grove, Illinois I Dallas, Texas

Request Effective with Tax Year:

W-2: ____________________
(current or future tax year)

FICA Match: ____________________
(New group - current or future tax year)
(Existing group - future tax year only)

Employer Name: ______________________________ Telephone Number: ______________________________

Contact Person: ______________________________ Fax Number: ______________________________

Employer Tax ID Number (EIN): ____________________ E-mail address ______________________________

Group Policy Number(s): ____

This Agreement Applies to: ☐ **Short Term Disability Only** ☐ **Long Term Disability Only** ☐ **Both STD and LTD**

A. W-2 Options for disability income benefits ("sick pay") - Choose Option 1 or Option 2:

W-2 Option may be selected up to November 15th of the current tax year.

☐ **OPTION 1. Insurer prepares W-2 statements for payees and files Federal and State information returns reporting sick pay.**

Employer hereby designates Insurer as its agent for the sole purpose of providing W-2 statements with sick pay information to payees by January 31st of each year, or such other date required by the Internal Revenue Service, and for making information return filings in accordance with Federal and State requirements regarding income tax, social security and Medicare tax. Insurer will use its EIN number on each of these forms. Employer is responsible for providing Insurer with all information necessary for Insurer to file timely and correct statements and returns, including the information necessary to determine the taxable portion of sick pay. The employee contributions made with after tax dollars will determine what portion of sick pay, if any, is excludable from employee's gross income. If Policy terminates, Insurer will continue to provide W-2 statements and make information return filings for sick pay payments on all claims incurred prior to termination of Policy.

NOTE: We will issue W-2's on a continuous basis, until notified differently by the Employer.

☐ **OPTION 2. Insurer DOES NOT prepare Form W-2 statements for payees and Federal and State information returns reporting sick pay.** If this option is chosen, Insurer will provide Employer by January 15th of each year with the information required by Federal law for Employer to prepare W-2s for its employees and file Federal and State information returns.

B. Employer FICA Options with respect to Employer's share of Social Security and Medicare taxes:

FICA Match Option can be selected as of your policy effective date for new groups. If you are an existing group, FICA Match Option can only be selected as of January 1st of the future tax year.

☐ **STANDARD. Employer retains responsibility for paying the Employer's share of Social Security and Medicare taxes.** Insurer will provide Employer with reports containing these amounts on a quarterly basis.

☐ **OPTION 1. Insurer pays the Employer's share of Social Security and Medicare taxes and deposits the taxes using the Insurer's EIN.** Employer will not be required to reimburse the Insurer for these amounts. Employer understands that the Employer FICA Match service will result in an increase of premium. If this Option is selected, the Insurer must prepare W-2 statements. Employer must select Option 1 in Section A.

C. General Sick Pay Reporting Requirements

Employer is responsible for providing Insurer with accurate information, including total wages paid employee during the calendar year, the last date the employee worked, and the employee contribution percentage of sick pay premium and whether these contributions were paid with BEFORE or AFTER tax dollars.

Insurer will notify Employer of the payments on which employee taxes were withheld. A weekly report will be sent to the Employer within the time required for Insurer's deposit of these amounts. Quarterly and Annual reports will also be sent to the Employer. Insurer will withhold and make timely deposits of employee Social Security and Medicare taxes.

Under no circumstances does Insurer assume any responsibility for Employer's portion of FUTA taxes or any other payroll or employment related tax, fee, premium or the like, including State disability insurance, State or local occupational tax or any Workers' Compensation tax which may be applicable to the sick pay.

Insurer agrees to withhold and deposit Federal income tax as required by the IRS or as requested by the employee on Federal W-4S form.

This Agreement will continue until replaced by a new Agreement, the Policy terminates and/or sick pay payments are discontinued. This Agreement replaces any prior dated Agreements.

EMPLOYER

Print Name: ______________________________ Signature: ______________________________

Title: ______________________________ Date: ______________________________

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Dearborn National™

Group Transmittal

Administrative Offices: Downers Grove, Illinois I Dallas, Texas

APPLICANT INFORMATION - Full legal name of Policyholder

____

Section 1. GENERAL INFORMATION

Eligibility: Your eligibility for insurance is as indicated in your proposal.

Minimum Hours Worked ______________________

Eligibility Waiting Period – Additional Questions:

1. Does the Eligibility Waiting Period for Group Insurance apply to all coverages?
   ❑ YES ❑ NO If NO, Please describe (attached separate sheet if necessary)

____

____

2. Does any Class have a different waiting period?
   ❑ YES ❑ NO If YES, Please describe (attached separate sheet if necessary)

____

____

Product Choice (check all that apply)	**Will this Policy replace an existing policy?**	**If yes, provide Carrier name (Note: a copy of the prior carrier's plan is required for claims administration)**	**Termination Date with Prior Carrier**	**Prior Employment Credit for Rehires - No prior credit unless requested below.** (Note: Prior Employment to Count for Employees Rehired Within **6 months**)
❑ Group Term Life & AD&D	❑ Yes ❑ No			❑ Yes ❑ No
❑ Group Dependent Term Life	❑ Yes ❑ No			❑ Yes ❑ No
❑ Group Short-Term Disability (STD)	❑ Yes ❑ No			❑ Yes ❑ No
❑ Group Long-Term Disability (LTD)	❑ Yes ❑ No			❑ Yes ❑ No
❑ Group Dental	❑ Yes ❑ No			❑ Yes ❑ No
❑ Supplemental Term Life & AD&D	❑ Yes ❑ No			❑ Yes ❑ No
❑ Voluntary Term Life	❑ Yes ❑ No			❑ Yes ❑ No
❑ Voluntary Term Life & AD&D	❑ Yes ❑ No			❑ Yes ❑ No
❑ Voluntary Short-Term Disability 50+ (VSTD)	❑ Yes ❑ No			❑ Yes ❑ No
❑ Vol. Short-Term Disability Income Protection (VSTD)	❑ Yes ❑ No			❑ Yes ❑ No
❑ Voluntary Long-Term Disability 50+ (VLTD)	❑ Yes ❑ No			❑ Yes ❑ No
❑ Vol. Long-Term Disability Income Protection (VLTD)	❑ Yes ❑ No			❑ Yes ❑ No
❑ Voluntary Group Dental	❑ Yes ❑ No			❑ Yes ❑ No

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Section 2. GROUP ADMINISTRATION

A. Document Delivery – Please indicate below

Document Delivery - Via Benefits Manager:

❑ **Benefits Manager** – The Group Administrator receives the Policy and Certificate documents through our secure Benefits Manager portal. A **Benefits Manager Registration Form** is required for customers choosing this option. When the documents are available, a Welcome notice email will provide instruction on accessing documents, and Administrative Guides available on our website is sent to the Group Administrator.

Document Delivery Via Email

❑ **Email Policy Documents and Certificates to Customer** - the Group Administrator will receive the Policy and certificate documents via email. A Welcome notice email will provide instructions on downloading forms and Administrative Guides, available on our website.

Email address of person to receive documents: ____

❑ Additional copy of policy/certificates to be sent to:

Name: ______________________ Email Address ______________________________

Name: ______________________ Email Address ______________________________

Name: ______________________ Email Address ______________________________

B. Billing

Is the Billing address different from the main policyholder address? ❑ Yes ❑ No If yes, please indicate below:

Company Name ______________________________ Attention: ______________

Address ____

City ______________________________ State __________ ZIP ______________

1. **Billing Type** (please select one below)

Groups 2-499 insured lives

❑ List Billing*

❑ Self-Administered** - Paper

❑ Self-Administered Web Billing* (25+ life groups only)

Groups 500+ insured lives

❑ Self-Administered** - Paper

(*Groups with 300+ lives require electronic census)

(Note: Dental is List Bill only)

OR ❑ **Third Party Administration (TPA)** - If TPA, please provide TPA name: ______________________

Is this a new FDL TPA? ❑Yes ❑ No If yes, a TPA Agreement, and copy of state license must be attached. Home Office approval must be obtained prior to submission.

Definitions:

*<u>**List Billing**</u> – Enrollment additions and deletions are managed by FDL or the employer and the bill is presented to the employer with individual enrollment information in paper form. Additions and deletions can also be managed by the employer via online access (Fort Access). *Note: Dental is always List Billed.*

<u>Self-Administered**</u> – All enrollment and individual coverage information is kept by the employer. This information is used to calculate premium. FDL provides a remittance reminder and varied format options for reporting coverage details and calculating premium.

<u>**Web Billing**</u> – A web based tool to assist in Self-Administered premium calculations. FDL provides initial enrollment details through our web based application and the employer maintains enrollment by managing additions, changes and terminations. FDL sends out a courtesy monthly email reminder for the employer to create their billing statement.

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Section 2. GROUP ADMINISTRATION (Cont)

2. Would you like specialized billing? ❑ Yes ❑ No If yes, please select one below:

❑ **A. Billing By Account** (This means you will receive Separate Billing statements sent to each Account address listed below. If this choice is selected, you anticipate paying each bill received with a separate check.)

a. Please indicate the name, address and contact name of each unit below or on an attached document; please provide subsidiaries or affiliates name and address for mailing;

b. State the amount of the premium deposit to be applied to each unit; and

c. Separate enrollment forms by unit OR highlight census.

Unit 1 Name ____ Attention: _____________________________________

Address ____

City ____ State ________________ ZIP ______________________

Unit 2 Name ____ Attention: _____________________________________

Address ____

City ____ State ________________ ZIP ______________________

Unit 3 Name ____ Attention: _____________________________________

Address ____

City ____ State ________________ ZIP ______________________

❑ **B. Billing by Location** (This means you will receive one billing statement, with employees separated by location/divisions with subtotals for the divisions. If this choice is selected, you anticipate paying the bill with one check. This choice is available for List and Web Billing options.)

a. Separate enrollment forms by unit OR highlight census.

b. Mailing Address:

Company Name ____ Attention: _________________________________

Address ____

City ____ State ________________ ZIP ______________

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Section 2. GROUP ADMINISTRATION (Cont)

Other Items

1. GROUPS WITH DISABILITY COVERAGE:

If the Employee pays any portion of the premium, indicate whether premium is deducted pre- or post-tax:

❑ Pre-Tax ❑ Post-Tax

- If the Employee pays any portion of the premium on a post-tax basis, this portion of the benefit is not taxable.
- If the Employee pays any portion of the premium on a pre-tax basis, this portion of the benefit is taxable.

FICA TAX/W-2 AGREEMENT - You must complete a FICA Tax/W-2 Agreement if you have applied for disability coverage. Please ensure your FICA Tax/W-2 agreement (attached) is complete and accurate prior to submission.

2. FORM 5500, SCHEDULE A

Does your group have 100 or more eligible employees? ❑ Yes ❑ No If Yes, benefit plan year: _ _ / _ _ /_ _ _ _

Information will be sent to the Group Contact indicated on the Application for Group Insurance unless indicated below.

Other: ____

3. Other Special Requests:

____

____

____

4. For Any Implementation Questions Regarding This Submission Please Contact:

Name ______________________________ Phone #: ____________________

Email Address: ____

____ ____________________

Signature of Benefit Administrator Date

(or any employee authorized to request plan changes - i.e. Corporate Officer)

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FORT DEARBORN LIFE
Insurance Company®

Benefits Manager Registration

Fort Dearborn Life Insurance Company (FDL) is excited you have chosen to register for the administrative solutions offered through Benefits Manager. Please fax the completed form to 1-312-540-8591. If you have questions regarding this form or the services available in Benefits Manager, please call customer service at 1-800-348-4512.

This form is to be completed by the Policyholder.

Group Coverage Information: Group #__________________ Account # ___________ State ____ Zip Code __________

Section I - *Benefits Manager Access*

☐ I request the ability to manage my group's enrollment and billing information online in real-time. I acknowledge that I will not receive a billing statement from FDL. I will obtain all invoices and remittance pages online using Benefits Manager. *Not available to groups with less than 25 lives.*

☐ I request the ability to manage my group's enrollment and billing information online in real-time. I will receive a regular billing statement from FDL. *Self-Administered groups will have access to billing information ONLY.*

As Policyholder I authorize the employee named below to access group, policy and EOI information as stated above via www.fdl-life.com. I understand that this will allow my employee to view, add, delete or edit membership information pertaining to our policy/or policies on this Web site.

Name: ______________________________ Company: ______________________________

Policyholder Signature: ______________________________ Date: ______________________________

User Information *(Please print clearly)*

First Name: ____________________ MI: _______ Last Name: ______________________________

Organization/Company: ______________________________ Phone: ( ) ________-____________

Mother's Maiden Name: ______________________________ Last Four Digits of SSN: ______________

Signature: ______________________________ Date: ______________________________

E-mail Address: ____

Section II - *Producer (Agent) Access*

As Policyholder:

☐ I authorize FDL to grant our Producer(s) access to our enrollment billing, and EOI information via www.fdl-life.com. I understand that this will allow our Producer(s) to view, add, delete or edit membership information pertaining to our policy/or policies on this Web site.

Policyholder Signature: ______________________________ Date: ______________________________

Producer Name: ______________________________

Producers Corner User ID: ______________________________

OR

Agency Name: ______________________________

Producer Names AND User ID's: *(Name, User ID; Name, User ID;)* ______________________________

Producer E-mail: ____

For FDL Office Use Only - *To be completed by a FDL employee.*

Role Required: Group Administrator

☐ FDL Web Billing Ext Admin/FDL GroupWeb EXT User/ EOI External Access

☐ FDL GroupWeb Ext User/FDL EOI External Access

☐ Multi-Group User

Attention GroupWeb Admin:

Member Enrollment ☐ Yes ☐ No

List subsidiaries/affiliates which will be administered by the above Benefit Administrator, if applicable.

Login ID *(6 character maximum)*	Group ID
FDL.GRP.	

Fort Dearborn Life Insurance Company will treat this information as confidential and will restrict access to the information as permitted by law, such as disclosures to our affiliates, agents, administrators, consultants and regulatory or governmental authorities, or as necessary to administer our Web sites and the insurance coverage's provided your Company.