FORT DEARBORN LIFE
Insurance Company®
Chicago, Illinois

Application for Group Insurance

Administrative Offices: Downers Grove, Illinois I Cleveland, Ohio I Dallas, Texas

PRODUCTS APPLYING FOR (check all that apply)**:** **GROUP #:** _____

- ❑ Group Term Life/AD&D, Supplemental Life/AD&D, Dependent Life (**Please complete Sections I, II, III & VI)**
- ❑ Group Short Term Disability **(Please complete Sections I, II, IV&VI)**
- ❑ Group Long Term Disability **(Please complete Sections I, II, V & VI)**

I. APPLICANT INFORMATION Please Type Or Print All Information

Policyholder (correct legal name) _____

Mailing Address _____

Address_____ (not P.O. Box) _____

City _____ State _____ ZIP _____

Phone_(____)_____ Fax (____)_____

Group Contact_____

Email Address_____

Subsidiaries or Affiliates?: ❑ 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	SIC Code	Effective Date 12:01 a.m.	First Anniversary

Annual Enrollment Period for Contributory Coverages, if applicable: From _____ to _____

W-2 Information: A W-2 Agreement must be completed and attached to this Application for all groups with Disability coverage.

II. GENERAL INFORMATION

Contributions: **Employer** will contribute:

Group Life/AD&D	❑ 100%	❑ Other_____ %
Dependent Life	❑ 100%	❑ Other_____ %
Supp. Life/AD&D	❑ 100%	❑ Other_____ %
STD	❑ 100%	❑ Other_____ %*
LTD	❑ 100%	❑ Other_____ %*

*Is employee disability contribution made with pre-tax dollars (Section 125)?

❑ Yes ❑ No

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

Eligibility Waiting Period:
- ❑ None
- ❑ First of month following completion of _____ Days
- ❑ Other _____

Eligibility Waiting Period applies to:
- ❑ All employees
- ❑ New employees only

Participation Requirements for Group Products: 75% – Contributory (excludes Supp. Life & Dep. Life) 100% – Noncontributory

	Group Life/AD&D	Supplemental Life/AD&D	Dependent Life	STD	LTD
Total eligible employees	_____	_____	_____	_____	_____
Total enrolled	_____	_____	_____	_____	_____

Initial Rates Guaranteed
Life/AD&D: for _____ months
STD: for _____ months
LTD: for _____ months

Premium Payable: ❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

Premium is due on the _____ day of each billing period.

FOR GROUPS OF 100 + ONLY

Form 5500, Schedule A ❑ Yes ❑ No

If Yes, benefit plan year is: _____

Account information should be sent to: _____

_____

III: SCHEDULE OF BENEFITS: LIFE and AD&D

1. ELIGIBLE CLASSES - DESCRIBE BELOW

Class 1 _____

Class 2 _____

Class 3 _____

All active employees who work at least _____ hours per week are eligible for coverage.
If blank, 30 hours per week will apply.

2. Prior Employment to Count for Employees Rehired Within 6 Months?
❑ Yes ❑ No

3. Will this policy replace an existing policy?: ❑ Yes ❑ No
If Yes: Carrier _____ (a copy of prior carrier's plan is required for claims administration)
Termination Date: _____

SELECTION OF COVERAGE(S) (fill in all applicable blanks)

Class	Group Life Insurance Amount of Insurance	AD&D Principal Sum	Supplemental Life Amount of Insurance	Supplemental AD&D Principal Sum
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____

Guarantee Issue (GI): $_____ Amounts in excess of the GI are subject to satisfactory evidence of insurability. *Supplemental $ _____

*Combined Group and Supplemental $_____

*Based upon a min. participation of _____%

Dependent Life Insurance (Benefit amounts are limited in some states)

Spouse: ..... $ _____

Does Spouse include Domestic Partner? ❑ Yes ❑ No

Child(ren): (select one) ❑ from live birth to 6 months ❑ from 15 days to 6 months $ _____
(select one) ❑ 6 months to 19 years* ❑ 6 months to age _____ $ _____
(select one) ❑ Other: _____ to age _____ $ _____
* To age _____ if full-time student(s) and dependent upon the insured for support.

GENERAL PROVISIONS (fill in all applicable blanks)

1. Life and AD&D benefits include 24-hour coverage.

2. If the Life and AD&D benefit is a multiple of salary, amount should be rounded to:
❑ the next higher ❑ the next lower ❑ the nearest multiple of $ _____.

3. Earnings for calculating salary based life insurance do not include bonuses, overtime, or any form of extra pay. If earnings are based in whole or in part on commissions, the benefit amount for life insurance will include the amount paid in commissions during the preceding 12-month period.

4. Group Life and AD&D benefits reduce by: ❑ 35% of the original amount at age 65, and further reduce to 50% at age 70.
❑ 35% of the original amount at age 65, and to 50% at age 70, and to 25% at age 75, and to 15% at age 80.
❑ _____% of the original amount at age _____, and to _____% at age _____, and to _____% at age _____, and to_____% at age _____.

5. Supplemental Life and AD&D benefits reduce by _____% of the original amount at age _____, and to _____% at age_____, and to _____% at age_____, and to _____% at age _____,

6. Life and AD&D benefits terminate at retirement unless otherwise noted in the Eligible Classes section.

7. Accelerated Death Benefit: ❑ 50% ❑ 75% ❑ 100%; Maximum Accelerated Death Benefit $_____; Minimum Death Benefit $_____

IV: SCHEDULE OF BENEFITS: SHORT TERM DISABILITY

1. ELIGIBLE CLASSES - DESCRIBE BELOW

Class 1 _____

Class 2 _____

Class 3 _____

Working a minimum of _____ regularly scheduled hours per week. If blank, 30 hours per week will apply.

2. Prior Employment to Count for Employees Rehired Within 6 Months?
☐ Yes ☐ No

3. Will this policy replace an existing policy?: ❑ Yes ❑ No
If Yes: Carrier _____ (a copy of prior carrier's plan is required for claims administration)
Termination Date: _____

4. Select one benefit and plan for each class:
Class 1: Flat Benefit of $_____/week or _____% of weekly earnings, up to a maximum of $_____
Class 2: Flat Benefit of $_____/week or _____% of weekly earnings, up to a maximum of $ _____
Class 3: Flat Benefit of $_____/week or _____% of weekly earnings, up to a maximum of $ _____

Guarantee Issue (GI): $_____ Amounts in excess of the GI are subject to satisfactory evidence of insurability.

5. Elimination Period:

_____ Days for Injury

_____ Days for Sickness

First Day of Hospital Confinement?
❑ Yes ❑ No

When should STD benefits begin? (choose one)

❑ Following the elimination period(s)
❑ When any compensation payments from the Policyholder cease, including but not limited to vacation pay, salary continuation or sick leave benefits.
❑ Other _____

6. Definition of Weekly Earnings will include (check all that apply):
❑ No commission or bonuses
❑ Bonuses
❑ Commissions
❑ W-2
❑ Other _____

Deferred Compensation Deductions (Section 125) included ?
❑ Yes ❑ No

7. Minimum Weekly Benefit:
❑ Not Applicable
❑ $ 25
❑ $ 100
❑ Other $_____

8. Pre-Existing Condition Limitation:
❑ None
❑ 3/12
❑ 12/12*
(*not available in PA)

9. Maximum Period Payable:
❑ 13 weeks
❑ 26 weeks
❑ 52 weeks
❑ Other _____

10. Partial Disability Earnings Test
❑ 80%
❑ 60%

12. Optional Features

A. Survivor Income Benefit Amount
❑ Yes ❑ No
❑ 3 times last weekly benefit
❑ Other _____

B. Worksite Modification
❑ Yes ❑ No
❑ $1,500
❑ _____ maximum

GENERAL PROVISIONS (fill in all applicable blanks)

1. STD benefits are payable for ❑ non-occupational disabilities only ❑ occupational & non-occupational disabilities
2. If STD benefits are payable for less than a week, pro-rate at ❑ 1/7 of the weekly amount ❑ 1/5 of the weekly amount*
*(only available if group has a Monday through Friday workweek)
3. STD weekly benefit, if Flat Benefit is selected, is subject to a maximum of _____ % of employee's weekly earnings.
4. Check here if any employees are located in ❑ CA ❑ HI ❑ NJ ❑ NY ❑ RI
5. 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.
6. STD benefit payments will be reduced by the amount the insured employee receives as disability income payments under any state compulsory benefit act or law.
7. A W-2 Agreement must be completed and attached to this Application if STD coverage is elected.
8. STD coverage terminates at retirement.

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V. SCHEDULE OF BENEFITS: LONG TERM DISABILITY

1. ELIGIBLE CLASSES - DESCRIBE BELOW

Class 1 _____

Class 2 _____

Class 3 _____

Working a minimum of _____ regularly scheduled hours per week. If blank, 30 hours per week will apply.

2. Prior Employment to Count for Employees Rehired Within 6 Months?
☐ Yes ☐ No

3. Will this policy replace an existing policy?: ❑ Yes ❑ No
If Yes: Carrier _____ (a copy of prior carrier's plan is required for claims administration)
Termination Date: _____

4. Elimination Period:
❑ 90 days Class_____
❑ 180 days Class_____
❑ Other _____ Class_____

5. Maximum Monthly Benefit: (If other than below, indicate on separate sheet)
Class 1: _____% of monthly earnings, up to a maximum of $_____
Class 2: _____% of monthly earnings, up to a maximum of $ _____
Class 3: _____% of monthly earnings, up to a maximum of $ _____

6. Definition of Monthly Earnings will include
(check all that apply):
❑ No commission or bonuses
❑ Bonuses
❑ Commissions
❑ W-2
❑ Other _____

Deferred Compensation Deductions (Section 125) included ?
❑ Yes ❑ No

7. Social Security Offset Method:
❑ Primary & Family
❑ Primary Only
❑ 70% All Sources

8. Minimum Benefit:
$_____
or
_____% of gross monthly income, whichever is greater.

9. Pre-Existing Condition Limitation:
❑ 3/12
❑ 3/6/12
❑ Other _____

10. Maximum Period Payable:
❑ Reducing Benefit Duration (ADEA-1)
❑ Social Security Normal Retirement Age
❑ 65/5/70 (ADEA-3)
❑ Other _____

11. Own Occupation:
❑ 24 months Class_____
❑ 36 months Class_____
❑ Other _____ Class_____

12. Partial Disability:
❑ 80%/60% (24 months/thereafter)
❑ 80%/80% (24 months/thereafter)
❑ 60%/60% (24 months/thereafter)
Pre-Disability Earnings Indexed? ❑ Yes ❑ No

13. Work Incentive Benefit/ Rehabilitation Incentive Income Calculation Method:
❑ Proportionate Loss
❑ 50% Offset

W-2 Information: A W-2 Agreement must be completed and attached to this Application for all groups with Disability coverage.

14. Indicate Benefits Selected - Please check "Yes" or "No" for each option:

A. ❑Yes ❑No Worksite Modification
❑ $1,500 ❑_____ Maximum

B. ❑Yes ❑No Education ❑ $300 ❑ _____

C. ❑Yes ❑No Survivor Income Benefit
Amount ❑ 3 times last monthly benefit ❑ _____
Benefit Payable ❑ Lump Sum ❑ Monthly

D. ❑Yes ❑No Family Income
Benefit Pct. ❑ 66 2/3% ❑ _____
Benefit Duration ❑ 1 year ❑ _____

E. ❑Yes ❑No Terminal Illness
Benefit ❑ 3 times last monthly benefit ❑ _____

F. ❑Yes ❑No COLA (Lesser of Pct. or CPI.)
❑ 3% ❑ _____
No. of Adjustments _____

G. ❑Yes ❑No Accidental Dismemberment Benefit

H. ❑Yes ❑No Catastrophic Disability
Benefit Pct. ❑ 10% ❑ _____
Maximum ❑ $5,000 ❑ _____
Elimination Period ❑ 180 days ❑ _____
Benefit Duration ❑ 12 months ❑ _____

I. ❑Yes ❑No Rehabilitation Benefit
Benefit Pct. ❑ 5% ❑ _____
Maximum ❑ $500 ❑ _____

J. ❑Yes ❑No Retirement Plan Protection Benefit
Pct ❑ 6% ❑ _____
Maximum ❑ $2,500 ❑ _____

15. Limitations:
❑Yes ❑No Mental Disorder ❑ 24 months ❑ Other _____
❑Yes ❑No Substance Abuse ❑ 24 months ❑ Other _____
❑Yes ❑No Special Conditions ❑ 24 months ❑ Other _____
Including self-reported conditions? ❑Yes ❑No
❑Yes ❑No Lifetime Cumulative Maximum ❑ 24 months ❑ Other _____

VI: 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. 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 Sections III, IV and/or V; and satisfies any other conditions required by the applicable group Policy.
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 (12) above.
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.

WARNING: 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.

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