



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 & V**)

Group Short Term Disability (**Please complete Sections I, II, III & V**)

Group Long Term Disability (**Please complete Sections I, II, IV & V**)

I. APPLICANT INFORMATION Please Type Or Print All Information

Policyholder (correct legal name) _____
 Mailing Address (not P.O. Box) _____
 Address _____
 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 affiliates on a separate sheet.)

Nature of Business	SIC Code	Effective Date 12:01 a.m.	First Anniversary
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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 <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Dependent Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Supp. Life/AD&D <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % STD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % LTD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %		Check if applicable: <input type="checkbox"/> Partnership <input type="checkbox"/> Subchapter S Corp. <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation			
Waiting Period: <input type="checkbox"/> None <input type="checkbox"/> First of month following completion of _____ Days <input type="checkbox"/> Other _____	Waiting Period applies to: <input type="checkbox"/> All employees <input type="checkbox"/> 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: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually		Premium is due on the _____ day of each billing period.		
Billing Method: <input type="checkbox"/> List Billed <input type="checkbox"/> Web Billing <input type="checkbox"/> Self-Administered <input type="checkbox"/> TPA Billed					
Premium Deposit: \$ _____ (approx. one month's premium)					
FOR GROUPS OF 100 + ONLY Form 5500, Schedule A <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, benefit plan year is: _____ Account information should be sent to: _____					



III: SCHEDULE OF BENEFITS

ELIGIBLE CLASSES - DESCRIBE BELOW

Class 1 _____
 Class 2 _____
 Class 3 _____
 Class 4 _____

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

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	Short-Term Disability Maximum Weekly Benefit
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____

- Weekly STD benefit is subject to a maximum of _____% of employee's basic weekly wage.
- STD Benefits Payable: _____ day of Accident _____ day of Sickness for a maximum of: _____ weeks
 1st day Hospital? Yes No
 Minimum Weekly Benefit (if applicable) _____
 Working Partial Disability Benefit Option Yes No Partial Disability Benefit Option Yes No
- Is Supplemental Life coverage portable? Yes No
- Is this policy replacing an existing policy? Yes No
 (If yes, a copy of prior carrier's plan is required for claims administration)
 Previous Company _____ Termination Date Of Prior Plan _____

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

Spouse: _____ \$ _____
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)

- Life and AD&D benefits include 24-hour coverage.
- 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 \$ _____.
- Earnings for calculating STD benefits or 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: (a) the benefit amount for life insurance will include the amount paid in commissions during the preceding 12-month period and (b) the benefit amount for STD will include the average of the amount paid in commissions during the preceding 12-month period. Benefit payment for STD is made at a daily rate of 1/7 of the weekly amount.
- Group Life and AD&D benefits reduce by: 35% of the original amount at age 65, and further reduce to 50% at age 70.
 _____% of the original amount at age _____, and to _____% at age _____, and to _____% at age _____.
- Supplemental Life and AD&D benefits reduce by _____% of the original amount at age _____, and to _____% at age _____, and to _____% at age _____.
- STD Benefits payable for non-occupational disabilities only.
- All benefits terminate at retirement unless otherwise noted in class definitions section.

GUARANTEE ISSUE (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)

Life: Group \$ _____ *Supplemental \$ _____ *Combined Group and Supplemental \$ _____
STD: \$ _____ *Based upon a min. participation of _____%



V: 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 for a loss incurred after the end of the grace period, 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 and/or IV; 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.

WARNING: Any person who who includes false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

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

Arkansas & 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.

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

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 containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas

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 information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties.

New Jersey - Applications

Any person who includes false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

New Jersey - Claims

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

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.

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.

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.

Washington

Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

All other states

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.)



Benefits Manager Registration

Fort Dearborn Life is excited you have chosen to register for the administrative solutions offered through Benefits Manager. Benefits Manager is designed to work with your groups chosen billing method. 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 # _____

Section I - Benefits Manager Access

I wish to manage my group's enrollment and billing information online in real-time. I acknowledge that I will not receive a regular billing statement from Fort Dearborn Life. I will obtain all invoices, including my remittance page online from Benefits Manager (Web Billing).

I require view-only online capability for my group's coverage, billing and payment information. I wish to still receive a regular billing statement from Fort Dearborn Life (List Billing/Self-Administered paper).

As Policyholder I authorize the employee named below to access group and policy information as stated above via Fort Dearborn Life's Web site (www.fdl-life.com).

Name: _____ Company: _____
Signature: _____ Date: _____

User Information (Please print clearly)

First Name: _____ MI: _____ Last Name: _____
Organization/Company: _____ Phone: () _____ - _____
Mother's Maiden Name: _____ Last Four Digits of SSN: _____
E-mail Address: _____ Signature: _____ Date: _____

Section II - Producer (Agent) Access

As Policyholder:

I authorize Fort Dearborn Life to grant our Producer(s) access to our billing and coverage information via www.fdl-life.com. I understand that this will allow our Producer(s) to view, add, delete or edit employee information pertaining to our policy/or policies on this website.

I do not authorize Producer access to our billing and coverage information via www.fdl-life.com.

Signature: _____ Date: _____
Producer Name: _____ Producer User ID: _____
Producer Name: _____ Producer User ID: _____

For FDL Office Use Only - To be completed by a Fort Dearborn Life employee.

Group Administrative Services:

Web Billing/Administrative Solutions (Web Billing)

Administrative Solutions Only (List or Self-Administered Billing)

Multi-Group User

Role Required: Group Administrator

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 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.