



**PART 1: APPLICANT INFORMATION** Please Type Or Print All Information

1. Policyholder (correct legal name) _____		Check if applicable:	
2. Mailing Address (not P.O. Box) _____		<input type="checkbox"/> Partnership	
Group Contact _____ Phone (____) _____		<input type="checkbox"/> Subchapter S Corp.	
3. Name of any: _____		<input type="checkbox"/> Sole Proprietorship	
<input type="checkbox"/> Affiliates <input type="checkbox"/> Subsidiaries to be covered _____		Fax _____	
IF SEPARATE BILLS ARE DESIRED, LIST ADDRESSES OF SUBSIDIARIES OR AFFILIATES ON A SEPARATE SHEET.			
4. Nature of Business _____	5. SIC Code _____	6. Effective Date _____	7. First Anniversary _____
8. Contributions: <b>Employer</b> will contribute:		9. Waiting Period	
Life/AD&D <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %		<input type="checkbox"/> None	
STD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %		<input type="checkbox"/> First of the month following completion of _____ Days	
Dependent Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %		<input type="checkbox"/> Premium due date following completion of _____ Days	
Other _____ <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %		<input type="checkbox"/> Other _____	
10. Waiting Period applies to:		11. Participation: 75% – Contributory	12. Total eligible employees _____
<input type="checkbox"/> All employees <input type="checkbox"/> New employees only		100% – Noncontributory	Total enrolled _____
13. As of the proposed effective date (Item 6 above), are any of your employees not Actively at Work (defined in Part 2 below)?			
<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please provide the following information: (attach a signed dated sheet if more space is needed)			
A. Name _____ Sex _____		Date of Birth _____	Benefit Amount \$ _____
Reason not Actively at Work: <input type="checkbox"/> Disability <input type="checkbox"/> Family Leave <input type="checkbox"/> Other _____		Date Last Worked _____	
B. Name _____ Sex _____		Date of Birth _____	Benefit Amount \$ _____
Reason not Actively at Work: <input type="checkbox"/> Disability <input type="checkbox"/> Family Leave <input type="checkbox"/> Other _____		Date Last Worked _____	
14. Initial Rates Guaranteed for _____ months (12 months for Critical Illness)		15. Premium Payable: <input type="checkbox"/> Monthly	16. Premium is due on the _____ day of each billing period.
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	
17. Billing Method: <input type="checkbox"/> List Billed	18. Premium Deposit:	19. Does this policy replace an existing policy? <input type="checkbox"/> Yes	
<input type="checkbox"/> Self-Administered	\$ _____	If Yes, list name of prior carrier: _____	
<input type="checkbox"/> TPA Billed	(approx. one month's premium)	<input type="checkbox"/> No	

**PART 2: GENERAL CONDITIONS**

It is understood and agreed that this application shall be made part of the Policy for which application is made. It is further understood:

1. 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 Part 3, Schedule of Benefits; and satisfies any other conditions required by the applicable group Policy.
2. This insurance is subject to the approval of Fort Dearborn Life Insurance Company, and nothing contained herein shall be binding upon Fort Dearborn until this application is approved and accepted at Fort Dearborn's home office.
3. No waiver or change will bind Fort Dearborn unless signed by an Executive Officer of the Company.  
The above information is true and accurate to the best of my knowledge. I understand that the information on this application and any other information I provide shall serve as the basis for the Policy to be issued, and that I have a duty to notify Fort Dearborn of any changes. I have relied upon no oral or written representations that contradict item (1) above.

**NOTE:** 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)

_____	_____
Policyholder/Authorized Signature	Date
_____	_____
Title	Licensed Resident Agent (if required)



**PART 3: SCHEDULE OF BENEFITS**

**CLASS DEFINITIONS** (if more than one class, definitions must be specific)

Class 1 \_\_\_\_\_  
 Class 2 \_\_\_\_\_  
 Class 3 \_\_\_\_\_  
 Class 4 \_\_\_\_\_

**Employees working less than 30 hours per week are not eligible for coverage unless otherwise noted above.**

**SELECTION OF COVERAGE(S)** (check all that apply and fill in all applicable blanks)

Class	<input type="checkbox"/> Life Insurance	<input type="checkbox"/> AD&D	Supplemental		<input type="checkbox"/> Short-Term Disability*
	Amount of Insurance	Principal Sum	<input type="checkbox"/> Life	<input type="checkbox"/> AD&D	Maximum Weekly Benefit
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____

\* **STD Benefits Payable:** \_\_\_\_\_ day of Accident; \_\_\_\_\_ day of Sickness for a maximum of \_\_\_\_\_ weeks.  
 1<sup>st</sup> day Hospital?  Yes  No **Refer to General Provisions 6, 7 and 8 Below**

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

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

**Critical Illness Benefit** Maximum Benefit \$ \_\_\_\_\_

**GENERAL PROVISIONS** (fill in all applicable blanks)

- Life and AD&D benefits include 24-hour coverage.
- If the benefit is a multiple of salary, amount should be rounded to:  
 the next higher  the next lower  the nearest multiple of \$ \_\_\_\_\_, if not already a multiple, not to exceed \$ \_\_\_\_\_.
- Salary does not include bonuses, overtime, or any form of extra pay. If salary is based in whole or in part on commissions, the benefit amount will include the amount paid in commissions during the preceding 12-month period.
- Basic Life and AD&D benefits reduce by \_\_\_\_\_% of the original amount at age \_\_\_\_\_, and further reduce to \_\_\_\_\_% of the original amount at age \_\_\_\_\_.
- Supplemental Life and AD&D benefits reduce by \_\_\_\_\_% of the original amount at age \_\_\_\_\_, and further reduce to \_\_\_\_\_% of the original amount at age \_\_\_\_\_.
- Weekly STD benefit is subject to a maximum of \_\_\_\_\_% of employee's basic weekly wage.
- Basic weekly wage does not include bonuses, overtime, or any form of extra pay. If weekly wage is based in whole or in part on commissions, the weekly benefit amount will include the average of the amount paid in commissions during the preceding 12-month period. Benefit payment is based on a 7-day work week.
- STD Benefits payable for non-occupational disabilities only.
- All Benefits terminate at retirement.

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

**Life:** Basic \$ \_\_\_\_\_ Supplemental \$ \_\_\_\_\_ Combined Basic and Supplemental \$ \_\_\_\_\_  
**STD:** \$ \_\_\_\_\_ **Other:** \_\_\_\_\_ \$ \_\_\_\_\_

**FOR GROUPS OF 100 + ONLY**

Form 5500, Schedule A  Yes  No If Yes, benefit plan year is: \_\_\_\_\_  
 Information should be sent to: \_\_\_\_\_ Insured Benefit Account  Yes  No