FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

Application for Voluntary Group Insurance

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

COVERAGES BEING APPLIED FOR (check all that apply):

☐ New Application ☐ Change*

GROUP #: ________________

☐ Voluntary Group Term Life ☐ Voluntary Group Long Term Disability (LTD)

☐ Voluntary Group Short Term Disability (STD) ☐ Voluntary Group Dental ☐ Voluntary Group Critical Illness

*To add benefits to your Voluntary Group Program, complete the items in Section I marked with an *, check additional coverage(s) in Section III, and read and sign Section IV.

I. APPLICANT INFORMATION Please Type Or Print All Information

*Applicant (Employer - correct legal name) ________________

Mailing Address (not P.O. Box) ________________

Physical Address ________________

Check if applicable:
☐ Partnership
☐ Subchapter S Corp.
☐ Sole Proprietorship

*Phone (   ) ________________ *Fax (   ) ________________

*Group Contact ________________ *Email Address ________________

Name of any Affiliates, Subsidiaries, or Divisions to be covered ________________

IF SEPARATE BILLS ARE DESIRED, LIST ADDRESSES OF SUBSIDIARIES OR AFFILIATES ON A SEPARATE SHEET.

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

Is this coverage offered as part of a Section 125 cafeteria plan? ☐ Yes ☐ No

W-2 Information: FDL to complete W-2 forms for each insured receiving disability coverage? ☐ Yes ☐ No

II. GENERAL INFORMATION

Waiting Period
☐ None
☐ First of the month following completion of ________ Days
☐ Premium due date following ________Days
☐ Other ________________

Waiting Period applies to:
☐ All employees
☐ New employees only

	Vol. Group Life/AD&D	Vol. Group STD	Vol. Group LTD	Vol. Group Dental	Vol. Group Critical Illness
Total eligible employees	________	________	________	________	________
Total enrolled employees	________	________	________	________	________

Initial Rates Guaranteed
Life: for ________ months
STD: for ________ months
LTD: for ________ months
Dental: for ________ months
CIB: for ________ months

Premium Payable:
Premium is due on the ________ day of each billing period.

Billing Method: ☐ List Billed ☐ On-line Web Billing ☐ Self-Administered ☐ TPA Billed

Premium Deposit: $________________ (approx. one month's premium)

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SECTION III: VOLUNTARY GROUP INSURANCE BENEFITS

To elect benefits for your Voluntary Group Program check coverage(s) below.

SCHEDULE OF BENEFITS

Plan(s) selected shall be available to all eligible employees.
If different, please describe eligibility class:______________________________

NOTE: All active employees who work at least __________ hours per week are eligible.
(If blank, the minimum of 20 hours will apply.)

☐ **VOLUNTARY GROUP TERM LIFE AND AD&D INSURANCE**

GI Amount*: ______________________________ Participation Level: ________%

* All eligible amounts are based on a minimum of 25% participation and may vary with the size of the group.

Term Life Benefit: Employee/Spouse Minimum $10,000; Maximum $500,000

Dependent Child Benefit: $5,000 or $10,000, 6 mo. To 18 yrs. (23 years if full-time student); $100, age 15 days to 6 mo.

AD&D Benefit Amount: Minimum $10,000; Maximum $500,000 (reduced maximum for employees over age 69)

☐ **VOLUNTARY GROUP SHORT TERM DISABILITY INCOME INSURANCE**

MAXIMUM Weekly BENEFIT AMOUNT (please check one)

☐ $750 ☐ $1150 ☐ Other ____________________ ($1150 Available to groups of 100+ employees only)
(Must be $50 increments)

Maximum Weekly Benefit may not exceed 60% of basic weekly income (weekly income includes state mandated or employer-sponsored income replacement benefits)

Do you currently have an employer-sponsored income replacement Plan? ☐ Yes ☐ No

Benefit Plan: (please check one) ☐ 1-8-13 ☐ 1-8-26 ☐ 1-8-52 ☐ Other ______________
☐ 15-15-13 ☐ 15-15-26 ☐ 15-15-52

- 12/12 Pre-Existing Condition Exclusion
- Benefits are payable for non-occupational disabilities only

Is STD a replacement of similar coverage? ☐ Yes ☐ No (*Copy of prior plan & last bill required for claims administration)

Prior Carrier______________________________ Date Terminated_____________

☐ **VOLUNTARY GROUP LONG TERM DISABILITY INSURANCE**

Elimination Period: (please check one) ☐ 90 days ☐ 180 days ☐ Other ____________________
Participation: _______________%

Benefit: (subject to coordination with other income benefits)

☐ Flat benefit in $50 increments not to exceed 60% of basic monthly earnings to a $5,000 maximum
☐ Other benefit: ______________________________

Benefit Duration:

☐ Plan I - 5 years Accident/2 years Sickness (Participation: 2 enrollees)
☐ Plan II - 5 years Accident/2 years Sickness (Participation: 6 employees and a minimum of 15% of the eligible group)
☐ Plan III - 5 years Sickness or Accident* (Participation: 6 employees and a minimum of 25% of the eligible group)
☐ Plan IV - Age 65 Sickness or Accident* (Participation: 6 employees and a minimum of 25% of the eligible group)

* 5 years/2 years plan will be issued if participation requirements are not met

- $100 Minimum Monthly Benefit
- 24 Month "Own Occ" Period
- 24 Month Mental Illness/Substance Abuse Limitation
- 12/6/24 Pre-Existing Condition Limitation (12/12 in CO, CT, NC, MD, WV, MS, MT, WI, SC)

Is LTD a replacement of similar coverage? ☐ Yes ☐ No (*Copy of prior plan required for claims administration)

Prior Carrier:______________________________ Date Terminated:_____________________

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☐ **VOLUNTARY GROUP CRITICAL ILLNESS INSURANCE***

Maximum Benefit $__________________________ Employer Contribution: ☐ None ☐ _________________

*not available in CA, CT, GA, IA, KY, NH, SC, MN and WA

☐ **VOLUNTARY GROUP DENTAL INSURANCE**

DENTAL BENEFIT PLANS: (Plan(s) selected shall be available to all eligible employees)

☐ SCHEDULED BENEFIT PLAN (Minimum Enrollment: 2 Eligible Employees)

Plan pays a scheduled amount to service provider based on coverage level, procedure and region.

Coverage Level (select one) ☐ Gold (with orthodontics) ☐ Silver ☐ Bronze
☐ Gold and Bronze ☐ Silver and Bronze

Region ☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5

☐ **REASONABLE & CUSTOMARY BENEFIT PLAN (R&C)** (Minimum Enrollment: 30 Eligible Employees)

Plan pays a percentage of the reasonable and customary charges based on coverage level and procedure.
The Additional Bronze Plan pays a scheduled amount to service provider based on procedure and region.

Coverage Level (select one) ☐ Gold R&C (with orthodontics) ☐ Gold R&C and Bronze Scheduled Plan
☐ Silver R&C ☐ Silver R&C and Bronze Scheduled Plan

Region (required only if a Bronze Plan is elected)
☐ Region 1 ☐ Region 2 ☐ Region 3 ☐ Region 4 ☐ Region 5

Is dental coverage a replacement for existing dental coverage: ☐ Yes ☐ No

Does this coverage include continuity of coverage for transfer insureds at takeover rates? ☐ Yes* ☐ No

Prior Carrier:____ Date Terminated:________________

*(Copy of prior plan and last list bill required for claims administration.)

Note: Certain coverages may be required to be offered in the state of issue. Such coverages, if any, are listed on an attached Supplement to Group Dental Insurance Application. Each coverage checked "Yes" is to be included. Each coverage checked "No" is not to be included.

SECTION 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 applicable 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 groups' 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 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.

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 ______________________