

**I. PARTICIPANT INFORMATION**

\*To add benefits to your Voluntary Program, complete the shaded sections of Part I, check additional coverage(s) in Part II, and sign.

New Application  Change\*

Name of Applicant (Participating Employer)	Contact (Name/Title)
--	----------------------

Mailing Address <small>(DO NOT USE P.O. BOX)</small>	Street	City	State	Zip
---	--------	------	-------	-----

Phone ( ) _____ Fax ( ) _____	Nature of Business	SIC Code
----------------------------------	--------------------	----------

Effective Date	First Anniversary	Number of Eligible Employees	Number Enrolled	Group Number
----------------	-------------------	------------------------------	-----------------	--------------

Waiting Period: <input type="checkbox"/> None <input type="checkbox"/> ___ Days <input type="checkbox"/> First of month following ___ days Applicable to: <input type="checkbox"/> All Employees <input type="checkbox"/> Future Employees Only	Is this coverage offered as part of a Section 125 cafeteria plan? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

**II. SCHEDULE OF BENEFITS (Plan or Plans selected shall be available to all eligible employees)**

**TERM LIFE AND AD&D INSURANCE**

**Term Life Benefit:** Employee/Spouse Minimum \$10,000; Maximum \$500,000  
 Dependent Child \$100, age 15 days to 6 months; \$5,000, 6 months to 18 yrs. (23 years if full-time student)  
 Additional Purchase Option: Class 1 \$\_\_\_\_\_ Class 2 \$\_\_\_\_\_ Class 3 \$\_\_\_\_\_  
**AD&D Benefit Amount:** Minimum \$10,000; Maximum \$500,000 (reduced maximum for employees over age 69)  
 Individual & Family Plans available

**SHORT TERM DISABILITY INSURANCE**

**Benefit:** Flat benefit in \$50 increments, not to exceed 70% of basic weekly income (*weekly income includes state mandated or employer-paid income replacement benefits*)

**Benefit Plan:** (select one)

- 1-8-13  1-8-26  1-8-52  
 15-15-13  15-15-26  15-15-52

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

**Plan Features:** Partial Disability Benefit • 12/12 Pre-Existing Condition Exclusion • Benefits are payable for non-occupational disabilities only • Minimum Weekly Benefit \$100 • Maximum Weekly Benefit \$750

Is STD a replacement of similar coverage?  Yes\*  No

Prior Carrier \_\_\_\_\_ Date Term'd \_\_\_\_\_

\*copy of prior plan required for claims administration

**CRITICAL ILLNESS** Maximum Benefit \$ \_\_\_\_\_

Employer Contribution:  None  \_\_\_\_\_

**LONG TERM DISABILITY INSURANCE**

**Elimination Period:** (select one)  90 days  180 days

**Benefit:** (subject to coordination with other income benefits)

- 60% of basic monthly earnings to a \$5,000 Maximum **OR**  
 Flat benefit in \$50 increments not to exceed 60% of basic monthly earnings to a \$5,000 maximum

**Benefit Duration:**  5 years Accident/2 years Sickness  
 5 years Sickness or Accident\*  
 Age 65 Sickness or Accident\*

\*5 years/2 years if participation requirements are not met

**Plan Features Include:**

\$100 Minimum Monthly Benefit • Progressive Partial Disability Benefit • 24 Month "Own Occ" Period • 12/6/24 Pre-Existing Condition Limitation • (12/12 in CO, CT, NC, MD, WV, MS, MT, WI, SC) • Primary & Family Social Security Integration • Full Maternity Benefit • 24 Month Mental Illness/Substance Abuse Limitation • 3 Month Survivor Benefit

Is LTD a replacement of similar coverage?  Yes\*  No

Prior Carrier \_\_\_\_\_ Date Term'd \_\_\_\_\_

\*copy of prior plan required for claims administration

**III. GENERAL CONDITIONS - It is understood that:**

- All active employees who work at least \_\_\_\_\_ hours a week are eligible (minimum 20 hours).
- Employee coverage is subject to the following conditions: Each employee must make written application to Fort Dearborn; his application must be accepted on the basis of such evidence of insurability as We may require; and he must be Actively at Work on his effective date.
- STD and LTD plans are not available to employees in NY.
- Premiums are due and payable monthly on the first day of each month.
- I have read and understand this entire application including the Agreement(s) on the reverse side. The above information is 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 insurance to be issued, and that I have a duty to notify the Company of any changes. I have relied upon no oral or written representations that contradict item (2) above.

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

Signed at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ Year: \_\_\_\_\_

\_\_\_\_\_  
 Authorized Signature \_\_\_\_\_  
 Licensed Resident Agent (If required)

**STATEMENT OF UNDERSTANDING**

between

FORT DEARBORN LIFE INSURANCE COMPANY ("FDL")  
and

\_\_\_\_\_ ("the Employer")

The Employer hereby grants FDL the right to offer each of the Employer's eligible employees, as defined in the application, the opportunity to participate in the Voluntary Benefit Program. This authorization is based on the following reciprocal agreements:

1. An enrollment will be conducted of the Employer's eligible employees. An initial enrollment period will be held from \_\_\_\_\_ through \_\_\_\_\_. Annual enrollment will be held \_\_\_\_\_.
2. The Employer agrees to provide a letter endorsing the Voluntary Benefit Program.
3. The Employer agrees to distribute FDL enrollment materials to all eligible employees.
4. The Employer agrees to collect and communicate to FDL acceptance or declination of the plan by each eligible employee.
5. The Employer will administer payroll deductions for the employees and remit premiums monthly on the first of each month.
6. The Employer agrees to notify FDL as soon as possible when the voluntary or involuntary termination of a participating employee takes place.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature / Employer

\_\_\_\_\_  
Authorized Signature / FDL

**APPLICATION FOR MEMBERSHIP IN THE GROUP INSURANCE TRUST**

(Complete only if coverage provided under the Trust)

The undersigned employer applies for membership in the Group Insurance Trust (the "Trust"). Application for membership includes group insurance provided under the master group policy(ies) issued by Fort Dearborn Life Insurance Company (the "Company") to the Trust.

1. Each participating employer shall subscribe to the Trust and adopt the terms and provisions of the Trust Agreement.
2. Each participating employer shall be bound by the provisions, conditions and limitations of the Master Group Policy, the General Conditions in the Application for Voluntary Benefits, and any applicable administrative provisions.
3. Insurance issued hereunder is in consideration of the Application of the Participating Employer and the payment of premiums when due.

Any Employer shall cease to be a participating employer under the Trust on the earliest of the following dates:

1. the date the employer no longer meets one or more of the requirements set forth in this application for membership;
2. the date he discontinues or suspends active business operations or is placed in bankruptcy or receivership;
3. the date his business loses its entity by means of dissolution, merger or otherwise; or
4. the date the Master Group Policy is terminated.

It is understood and agreed by the undersigned that the Trustee is not an insurer, nor does he have any obligation under any policy of insurance. All claims for and benefits provided by the insurance applied for shall be made to and payable by the Company in accordance with the provisions of such policy(ies). The Trust Agreement and Master Group Policy(ies) held by the Trustee are available for inspection during regular business hours at the office of the Company.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature / Employer