



1020 31st Street, Downers Grove, IL 60515
Customer Service: (800) 348-4512; Fax: (312) 240-0143

Chicago, Illinois **Administrative Offices:** Downers Grove, Illinois Cleveland, Ohio Dallas, Texas

EMPLOYEE NAME – LAST	FIRST	MIDDLE INITIAL	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)		EARNINGS \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	JOB TITLE		CLASS
EMPLOYER		GROUP NO. /ACCOUNT NO.		LOCATION	

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

		Voluntary Life <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del.	Voluntary AD&D <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del.	Other <input type="checkbox"/> Yes <input type="checkbox"/> No	
		\$	\$	\$	
VOLUNTARY COVERAGE (S) (Evidence of Insurability may be required on employee and spouse Life and Critical Illness Insurance)		(A)dd (C)hange (D)elete	Total Amount of Coverage Applied, for	If (C), my prior coverage was	
Voluntary Term Life: Employee <input type="checkbox"/> YES <input type="checkbox"/> NO					
Voluntary Term Life: Spouse <input type="checkbox"/> YES <input type="checkbox"/> NO					
Voluntary Term Life: Dependent Child(ren) <input type="checkbox"/> YES <input type="checkbox"/> NO					
Voluntary AD&D: Individual Plan <input type="checkbox"/> YES <input type="checkbox"/> NO					
Voluntary AD&D: Family Plan <input type="checkbox"/> YES <input type="checkbox"/> NO					
SPOUSE NAME-LAST (if applicant)	FIRST	M.I.	SEX M <input type="checkbox"/> F <input type="checkbox"/>	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #
Has Employee (if applicant) used cigarettes or other tobacco products in the last 2 years? <input type="checkbox"/> YES <input type="checkbox"/> NO			Has Spouse (if applicant) used cigarettes or other tobacco products in the last 2 years? <input type="checkbox"/> YES <input type="checkbox"/> NO		

Review the following guidelines which apply to voluntary coverage(s)

- You may enroll, apply for additional coverage, or request a change to current voluntary benefits only during a scheduled enrollment period.
- If your earnings are based in whole or in part on commissions, commissions will be averaged over the 12-month period prior to the date disability begins.

BENEFICIARY DESIGNATION (For Employee Only: Must Be Completed if you have applied for life or AD&D insurance) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100% (Employee is the beneficiary of proceeds from spouse or child coverage.)

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY #	BENEFIT %
Primary					%
Primary					%
Contingent					%

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK ON THE EFFECTIVE DATE OF MY COVERAGE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I RETURN TO WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

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 OR or VA)

EMPLOYEE SIGNATURE _____ DATE ____/____/____

FOR FDL USE ONLY

(Please Print)

PART I: TO BE COMPLETED BY POLICYHOLDER	FOR FDL USE ONLY	
Group Number _____	EMPLOYEE <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Smoker	SPOUSE <input type="checkbox"/> Approved <input type="checkbox"/> Declined <input type="checkbox"/> Smoker
Group Name and Address _____	<input type="checkbox"/> Cancelled <input type="checkbox"/> Nonsmoker	<input type="checkbox"/> Cancelled <input type="checkbox"/> Nonsmoker
Group Contact _____ (Print Name & Title)	GI <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____	GI <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____
Telephone (_____) _____	AMOUNT APPROVED \$ _____ Eff. Date _____	AMOUNT APPROVED \$ _____ Eff. Date _____
	Reviewed by _____ Date _____	Reviewed by _____ Date _____
	CHILD(REN) <input type="checkbox"/> Approved <input type="checkbox"/> Declined Eff. Date: _____	State Code _____ Agency (CB)(TPA) _____
	New Hire Waiting Period _____	<input type="checkbox"/> Self-Admin <input type="checkbox"/> Direct Bill _____

PART II: TO BE COMPLETED BY EMPLOYEE										
<input type="checkbox"/> Voluntary Life <input type="checkbox"/> Amount over Guarantee Issue <input type="checkbox"/> Late Enrollment										
Employee Name		Last	First	M.I.	Date of Birth		Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	State of Birth	
Home Mailing Address - Street			City	State	Zip	Work Telephone ()		Home Telephone ()		
Social Security #	Employee Height ft. in.		Weight lbs.	Spouse/Dep. Height ft. in.		Weight lbs.				
Spouse/Dep	Last	First	M.I.	Social Security #		Date of Birth	Age	State of Birth		

PART III: INSURABILITY QUESTIONNAIRE (Underline condition & record details in PART IV.)	Employee	Spouse/Dep.
1. Have you used cigarettes or other tobacco products in the last 2 years?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Within the past 5 years, have you been medically counselled or treated for, or been told by a medical practitioner that you had: heart murmur; high blood pressure; heart attack; any disease of the heart or blood vessels; diabetes; albumin; blood or sugar in urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disease of the stomach, liver or intestines; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Within the past 5 years have you been diagnosed by or received treatment from a member of the medical profession for AIDS or ARC (AIDS Related Complex) or any other immunological disorders?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Within the past 5 years have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Are you presently receiving any treatment by a medical practitioner or taking any medication?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Have you ever been rated, declined, postponed or limited in any way for life, health, accident or sickness insurance?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

PART IV: Provide details of all 'YES' answers given to questions in PART III. – If additional space is required, attach a separate signed and dated sheet.

Question # & Individual	Illness/Reason for Checkup or Doctor's Treatment/Consultation	Dates From To	Full Name, Complete Address and Telephone # of Attending Physician or Other Practitioner

YOU MUST COMPLETE BOTH PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.

Employee Name _____ Social Security # _____

WARNING: 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)

AGREEMENTS AND AUTHORIZATION: I, the undersigned applicant(s), have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Fort Dearborn Life Insurance Company (FDL) shall not be liable for any claim arising prior to the date of approval of this application at FDL's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, medical facility, medical provider, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize FDL to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB Group, Inc. a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information disclosed may be redisclosed and no longer protected by federal privacy laws;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- Coverage will not become effective until FDL approves my application, provided that I am actively at work on that day.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from FDL.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

Signature of Employee

Date

Signature of Spouse (if requesting insurance)

Date

Signature of Dependent Child (if to be insured and of age of majority)

Date

Fort Dearborn Life Insurance Company
Chicago, Illinois

DISCLOSURE

(retain with your insurance records)

Thank you for enrolling for Group Insurance with Fort Dearborn Life Insurance Company. To assist us in processing the group policy, your signature on the Agreements and Authorizations section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Fort Dearborn Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply each company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston MA 02112, telephone number (617) 426-3660.

Fort Dearborn Life Insurance Company or its designated representative(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.