

New Change

PLEASE TYPE OR PRINT WITH BALLPOINT PEN.

NAME OF EMPLOYEE – LAST	FIRST	MIDDLE INITIAL	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH MO / DAY / YEAR	DATE OF HIRE (FULL TIME) MO / DAY / YEAR
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SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)

EMPLOYER	GROUP NO.	AGENCY
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Irrevocable Beneficiary: Yes No **Note:** If you select irrevocable beneficiary, you may not change the beneficiary without the consent of the irrevocable beneficiary. An irrevocable beneficiary has a vested interest in the proceeds of the contract, therefore the contract holder cannot exercise certain rights without the permission of the irrevocable beneficiary.

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%. SEE BELOW FOR DETAILS.

	First Name	Last Name	Date of Birth	Social Security Number	Relationship	Benefit %
BENEFICIARY Must Be Completed	Primary		MO / DAY / YEAR			%
	Primary		MO / DAY / YEAR			%
	Contingent		MO / DAY / YEAR			%
	Contingent		MO / DAY / YEAR			%

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.)

SIGNATURE OF EMPLOYEE OR MEMBER _____

DATE SIGNED ____ / ____ / ____
MO DAY YEAR

FOR FDL USE ONLY Effective Date / /
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Important Note For Married Employees: If you live in a community property state, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NM, NV, TX, WA and WI. Payment of benefits may be delayed or disputed unless your spouse consents to waive his or her rights to any community property interest in the benefits. We have provided below a "Spousal Consent for Community Property States" for your spouse's signature. **FORT DEARBORN WILL NOT BE LIABLE FOR DAMAGES DUE TO ANY DELAY OR DISPUTE IN PAYMENT OF BENEFITS IF YOU CHOOSE NOT TO OBTAIN YOUR SPOUSE'S SIGNATURE.**

Spousal Consent for Community Property States: I hereby consent to the Primary Beneficiary designated by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature _____ Date _____ Employee has no legal spouse

Primary Beneficiary: The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary. **If you specify benefit percentages, the total must equal 100%.** If you do not specify benefit percentages, proceeds will be paid in equal shares to the primary beneficiaries who survive you.

Contingent Beneficiary: The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. **If you specify benefit percentages, the total must equal 100%.**

No Beneficiary: If you do not name a beneficiary, or if no beneficiary survives you, we will pay death benefits in the order of survivorship shown in your group certificate.

Administrative Offices: Downers Grove, Illinois | Dallas, Texas

EMPLOYER: If group is self-administered, submit enrollment form **only** if evidence of insurability is required. If group is not self administered, submit enrollment form to us.

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.**

BASIC COVERAGE(S)				Supplemental Life	Supplemental AD&D	Other _____
Basic Life/AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO	STD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	LTD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	Dependent Life <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del. \$ _____	<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del. \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____

VOLUNTARY COVERAGE(S) (Evidence of Insurability may be required on employee & spouse/registered domestic partner Life 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/Registered Domestic Partner <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: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> NO			
Voluntary Short-Term Disability <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Long-Term Disability - Incremental <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Long-Term Disability - % of Salary <input type="checkbox"/> YES <input type="checkbox"/> NO			

SPOUSE/REGISTERED DOMESTIC PARTNER NAME (IF APPLICANT) LAST FIRST M.I.			SEX M <input type="checkbox"/> F <input type="checkbox"/>	SPOUSE/REGISTERED DOMESTIC PARTNER DATE OF BIRTH	SPOUSE/REGISTERED DOMESTIC PARTNER 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.
- Your weekly STD benefit may not exceed 60% of your basic weekly earnings (excluding bonuses, overtime and any extra compensation other than commissions).
- If you are eligible for state-mandated temporary disability benefits, or any employer sponsored income replacement benefits, the combination of your state mandated benefit or other income benefit and your STD weekly benefit may not exceed 60% of your basic weekly earnings.
- New Voluntary STD plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA).
- Your Voluntary LTD benefit for incremental plans may not exceed 60% of your basic earnings (excluding bonuses, overtime and any extra compensation other than commissions).
- New Voluntary LTD plans and benefit increases are subject to a pre-existing condition limitation. Your certificate of coverage will fully explain this limitation.
- 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 AS DEFINED IN THE POLICY ON THE DATE MY COVERAGE WOULD OTHERWISE BECOME EFFECTIVE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I MEET THE POLICY DEFINITION OF ACTIVELY AT 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 materials thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

EMPLOYEE SIGNATURE _____ DATE ____/____/____

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