FORT DEARBORN LIFE
Insurance Company®
Chicago, Illinois

Evidence of Insurability

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

PART I: TO BE COMPLETED BY POLICYHOLDER (Please Print) An enrollment form must accompany this application.

Group Number_____

Group Name and Address

Group Contact_____
(Print Name)

Group Contact_____
(Print Title)

Telephone (_____) _____

FOR FDL USE ONLY

EMPLOYEE	SPOUSE
☐ Approved ☐ Declined ☐ Smoker ☐ Cancelled ☐ Nonsmoker	☐ Approved ☐ Declined ☐ Smoker ☐ Cancelled ☐ Nonsmoker
GI ☐ No ☐ Yes $ _____	GI ☐ No ☐ Yes $ _____
AMOUNT APPROVED $_____ Eff. Date_____	AMOUNT APPROVED $_____ Eff. Date_____
Reviewed by _____ Date_____	Reviewed by _____ Date_____
CHILD(REN) ☐ Approved ☐ Declined Eff. Date: _____	State Code AZ _____ Agency (CB)(TPA) CSA _____
New Hire Waiting Period _____	☐ Self-Admin ☐ Direct Bill ____

PART II: TO BE COMPLETED BY EMPLOYEE ☐ **Voluntary Life** ☐ **Amount over Guarantee Issue** ☐ **Late Enrollment**

Employee Name Last	First	M.I.	Date of Birth / /	Age	Sex ☐ M ☐ 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?	☐ Y ☐ N	☐ Y ☐ 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?	☐ Y ☐ N	☐ Y ☐ 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?	☐ Y ☐ N	☐ Y ☐ 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?	☐ Y ☐ N	☐ Y ☐ N
5. Are you presently receiving any treatment by a medical practitioner or taking any medication?	☐ Y ☐ N	☐ Y ☐ N
6. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?	☐ Y ☐ N	☐ Y ☐ N
7. Have you ever been rated, declined, postponed or limited in any way for life, health, accident or sickness insurance?	☐ Y ☐ N	☐ Y ☐ 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.
Retain a copy of this application for your records.

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

(Please 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 Authorization 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 866-692-6901 (TTY 866-346-3642).

Fort Dearborn Life Insurance Company, its reinsurers, or 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.

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Fraud Notices

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

The laws of some states require us to furnish you with the following notice:

Arizona & New Jersey - Claims

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Arkansas & Massachusetts

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware, Idaho & Oklahoma

Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

District of Columbia & Virginia

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana & New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New Hampshire

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey - Applications

Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

Texas

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Washington

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other States

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)