FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

Enrollment and Change Form
PPO Group Dental Plan-4 Tier

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

Applicant: Please print or type. Complete all areas, sign and date. Do not write in shaded areas.

Applicant:	☐ New Employee	☐ Open Enrollment	☐ COBRA	☐ Retiree

Applicant Name:	For Office Use Only	Group No. ______________ Effective Date ____________

Home Address	Date of Birth / /	Sex ☐ Male ☐ Female

City	State	ZIP Code	Home Telephone No. ( )	Business Telephone No. ( )

Your Employer	Date of Hire (full-time)	Social Security Number - -

Employer Address (street, city, state, ZIP)

Spouse Information - complete only if spouse is to be covered.

Name of Spouse (First MI Last - only if different)	Is your spouse covered under any other dental plan? ☐ Yes ☐ No	Marital status ☐ Married ☐ Separated	Date of Birth / /	Sex ☐ Male ☐ Female

Dependent Child(ren) - list only those children to be covered.

Name (First MI Last-only if different)	Date of Birth	Relationship	Sex	Check if over age limit	Name of accredited school
	/ /		☐ Male ☐ Female	☐ Full-time student ☐ Handicapped child	
	/ /		☐ Male ☐ Female	☐ Full-time student ☐ Handicapped child	
	/ /		☐ Male ☐ Female	☐ Full-time student ☐ Handicapped child	
	/ /		☐ Male ☐ Female	☐ Full-time student ☐ Handicapped child	

Enrollment/Change

☐ Select Plan	☐ Initial Enrollment	☐ Policy Change (check reason for change)	☐ Cancel Coverage
☐ PPO Gold	☐ Employee	☐ Married ☐ Birth/Adoption	☐ Terminate Coverage Date: ____________
☐ PPO Silver	☐ Employee + Spouse	☐ Widowed ☐ Address Change	☐ Waive Coverage
☐ PPO Bronze	☐ Employee + Child(ren)	☐ Divorced	☐ Leave / Lay Off
	☐ Family		☐ Other ____________ Date: ____________

COBRA Continuation Privilege: Start Date: ________/________/________

Previously covered with group as:
☐ 1. Employee (termination of employment, reduction in hours, other.)
☐ 2. Spouse (divorce from employee, death of employee.)

Projected End Date: ________/________/________
☐ 3. Dependent (reached age limit, married, no longer full-time student, other.)
☐ 4. Spouse & Dependents (divorce from employee, death of employee, other.)

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

Employee/Applicant Signature ____ Date ________________

Application for Coverage:

I authorize my employer to deduct from my pay any contribution required of me toward the cost of elected dental coverage.

The undersigned on behalf of himself/herself and his/her dependent children, if any, in this application agree to cooperate in providing Fort Dearborn Life Insurance Company or its appointed representative with information needed to process this application or process eligible benefits.

I further understand that I must be actively at work before coverage will become effective. 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.

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, VA or VT.)

Employee/Applicant Signature ____ Date ________________