

I: APPLICANT INFORMATION

Employer Name (correct legal name) _____
 Mailing Address (not P.O. Box) _____
 City _____ State AZ Zip Code _____
 Group Contact _____ Phone _____ Email Address: _____

SIC Code / Nature of Business _____/_____	Effective Date _____
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Contributions: Employer will contribute: (Minimum of 25%)

<input type="checkbox"/> Life/AD&D	<input type="checkbox"/> 100%	<input type="checkbox"/> Other _____ %
<input type="checkbox"/> Dependent Life	<input type="checkbox"/> 100%	<input type="checkbox"/> Other _____ %
<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> 100%	<input type="checkbox"/> Other _____ %
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> 100%	<input type="checkbox"/> Other _____ %

Coverage Applying for: (Select one)

<input type="checkbox"/> Life/AD&D	<input type="checkbox"/> Life/AD&D/Long Term Disability/Dependent Life
<input type="checkbox"/> Life/AD&D/Dependent Life	<input type="checkbox"/> Life/AD&D/Short Term Disability/Long Term Disability
<input type="checkbox"/> Life/AD&D/Short Term Disability	<input type="checkbox"/> Life/AD&D/Short Term Disability/Long Term Disability/Dependent Life
<input type="checkbox"/> Life/AD&D/Short Term Disability/Dependent Life	<input type="checkbox"/> Short Term Disability/Long Term Disability
<input type="checkbox"/> Life/AD&D/Long Term Disability	

Eligibility: (Select one)

All active employees who work at least 30 hours per week are eligible for coverage.
 20 hours (Will be allowed for groups with such current eligibility. Proof of such eligibility is required.)

Waiting Period applies to: <input type="checkbox"/> All Employees <input type="checkbox"/> New Employees Only	Waiting Period: <input type="checkbox"/> First of the month following completion of 30 Days <input type="checkbox"/> First of the month following completion of ___ Days (minimum of 30 days)
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Participation: 2-4 employees: 100% must enroll 5-7 employees: All but 1 must enroll 8-9 employees: All but 2 must enroll	Total Eligible Employees _____ Total Enrolled _____	Premium Payable: Monthly
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II. ELIGIBLE CLASSES and SELECTION OF COVERAGE(S)– Describe Below

Life/AD&D Insurance

	Flat Benefit Amount:	Annual Salary Based:			Minimum Benefit:	Maximum Benefit:
		1x	2x	3x		
Class 1 _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____
Class 2 _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____
Class 3 _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____

(Maximum Benefit Allowed: \$100,000)

LIFE GUARANTEE ISSUE (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)
 Life: 2-5 eligible lives: \$35,000 6-9 eligible lives: \$50,000

Dependent Life

Spouse \$ _____
 Child(ren) \$ _____ Birth to 6 months \$ _____ 6 Months to 19 (23)*

*To age 23 if full-time student; Full-time student age varies by state. Please refer to Certificate.

II. ELIGIBLE CLASSES and SELECTION OF COVERAGE(S) -- Describe Below

Short Term Disability
(Same Class Description as Life/AD&D)

	Flat Benefit Amount:	Percent of Weekly Income:			Maximum Benefit:
		50%	60%	66 2/3%	
Class 1 _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Class 2 _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
Class 3 _____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____
	(Max Flat Benefit Allowed: \$250.00)				(Maximum Benefit Allowed: \$750.00)

STD Benefits Payable: ____ day of accident; ____ day of Sickness for a maximum of ____ weeks*. Plan applies to all Classes.
(*13 week plan not available in Vermont)

Long Term Disability

Class 1 All active full time employees 60% of monthly earnings to \$ _____
(Maximum Monthly benefit allowed: \$6,000)

Elimination Period: (Select one) 90 days 180 days

Maximum Benefit Duration: (Select one) Social Security Normal Retirement Age (SSNRA)
 5 Years or Age 70, whichever first occurs

Does this policy replace an existing policy? Yes No If Yes, provide a copy of prior carrier benefit booklet (for LTD only)

Previous Company _____ Termination Date of Prior Plan _____

GENERAL PROVISIONS

- Life and AD&D benefits include 24-hour coverage.
- If the benefit is a multiple of salary, amount will be rounded to the next higher multiple of \$1,000, if not already a multiple.
- Earnings for calculating STD and/or LTD benefits or salary based life insurance do not include bonuses, overtime, or any form of extra pay. If earnings are based in whole or in part on commissions: (a) the benefit amount for life insurance will include the amount paid in commissions during the preceding 12-month period and (b) the benefit amount for STD and/or LTD will include the average of the amount paid in commissions during the preceding 12-month period. Benefit payment for STD is made at a daily rate of 1/7 of the weekly amount.
- Life and AD&D benefits reduce by 35% of the original amount at age 65, further reduce to 50 % of the original amount at age 70, further reduce to 25% of the original amount at age 75, and further reduce to 15% of the original amount at age 80. All benefits terminate at retirement.
- STD Benefits payable for non-occupational disabilities only, except where prohibited by law.
- All Benefits terminate at retirement.

III. Authorizations

The undersigned employer and/or authorized representative hereby request that it be approved for insurance coverage through Fort Dearborn Life Insurance Company (FDL). The employer agrees to payment of the required premiums if approved for coverage. The undersigned understands, represents to the best of his knowledge, believes and certifies to:

- Comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the FDL trust policy(ies), if applicable;

- Make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
- Maintain records and furnish FDL or their designated agent(s), any information required in connection with administration of the insurance coverage;
- Provide notice of applicable conversion rights to eligible employees and eligible dependents;
- Pay FDL by the premium due date, the premiums on behalf of each employee covered under the contract, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;

Fort Dearborn Life Insurance Company

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

Participation Agreement

Please Type or Print All Information

Further, the undersigned agrees that:

- 6. Claims filed by or on behalf of employees may, at FDL’s option, be suspended if premiums are not received timely;
- 7. The premium deposit does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on FDL’s determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of FDL except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
- 8. In order for FDL to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, FDL, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application.
- 9. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to FDL by the employer. Any misstatements on employees’ applications or failure to report new medical information prior to the employees’ effective dates may result in a material change to the group’s coverage or premium rate as of the effective date of coverage;
- 10. The entire application for Group Insurance has been reviewed, and all answers contained herein are true and complete to the best of the employer’s and/or authorized representative’s knowledge and belief;
- 11. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, and meet all eligibility requirements for coverage;
- 12. Being Actively at Work is a requirement for coverage. If an employee is not Actively at Work on the day his coverage would otherwise be effective, the effective date of his coverage will be the date of his return to Active Work. If an employee does not return to Active Work, he will not be covered. The terms “Actively at Work” and “Active Work” mean that an employee is performing the normal duties of his occupation; is working the number of hours specified in Section I; and satisfies any other conditions required by the applicable group Policy.
- 13. The requested coverage is not in effect unless and until this application is approved by FDL, that approval of coverage shall be evidenced by issuing insurance certificates to the employer and employees, or other notification that risk has been accepted, and an employee’s coverage is not in effect unless and until the employee applies and is approved for coverage by FDL. The employer agrees that it will not collect any premium from employees requiring medical underwriting until notified of the approval of the employee’s application for coverage.
- 14. It is understood and agreed that this application shall be made part of the Policy for which application is made. I have relied upon no oral or written representations that contradict item (12) above.

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 may subject such person to criminal and civil penalties. (Not enforceable in Oregon and Virginia).

Authorized Signature

Date

Title

Licensed Resident Agent (if required)

Broker Certification: I hereby certify that: (1) I have reviewed the attached employee enrollment forms and group applications for completeness and accuracy. (2) I am not aware of any health history of any applicant that does not appear on the enrollment form. (3) I have not completed any of the information contained in the enrollment form except with permission of the applicant and as noted by my initials on the enrollment form. (4) I have not signed any of the enrollment forms for a group representative or individual applicant. (5) I have fully explained to the Employer that an employee not actively at work on the policy effective date or their eligibility date will not be covered until such employee returns to active work full-time. (6) I have explained that no premium should be collected from or on behalf of any employee requiring medical underwriting prior to approval of the employee’s application by the Insurer. (7) I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or a re-rating of the group’s premium retroactive to the effective date of coverage, and that coverage shall not be effective until FDL reviews and approves the application and the group receives a written notice and contract from FDL. (8) I am licensed in the state of this group for the types of insurance solicited.

Print Name

Signature

Date



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

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.

District of Columbia

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 containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas

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 information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties.

New Jersey

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

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.

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.

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

Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

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 Oregon or Virginia.)