FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

☐ New Enrollment ☐ Change **Enrollment Form**

Administrative Offices: Downers Grove, Illinois | Cleveland, Ohio | 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 F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)	EARNINGS $ Weekly Monthly 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 COVERAGE (S) (Evidence of Insurability may be required on employee and spouse Life Insurance)	**(A)dd (C)hange (D)elete**	**Total Amount of Coverage Applied, for**	**If (C), I am Increasing Existing by**	**If (C), I am Decreasing Existing by**
Voluntary Term Life: Employee YES NO				
Voluntary Term Life: Spouse YES NO				
Voluntary Term Life: Dependent Child(ren) YES NO				
Voluntary AD&D: Individual Plan YES NO				
Voluntary AD&D: Family Plan YES NO				

SPOUSE NAME-LAST FIRST M.I. (if applicant)	SEX M F	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #
Has Employee (if applicant) used cigarettes or other tobacco products in the last 2 years? YES NO		Has Spouse (if applicant) used cigarettes or other tobacco products in the last 2 years? YES 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 any open 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 paid 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.
- 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					%
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.

WARNING: Any person who, with intent to defraud or knowing that his facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (ORC Section 3999.21) (not enforceable in OR or VA)

FOR FDL USE ONLY

EMPLOYEE SIGNATURE _____ DATE ____/____/____

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