



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 <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"/> 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 and spouse Life and Critical Illness 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 <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			
Voluntary Critical Illness with Cancer Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO			
Voluntary Critical Illness without Cancer Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO			

SPOUSE NAME - LAST (if applicant)	FIRST	M.I.	SEX M <input type="checkbox"/> F <input type="checkbox"/>	SPOUSE DATE OF BIRTH	SPOUSE 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 material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (Not enforceable in OR or VA.)

EMPLOYEE SIGNATURE _____ DATE ____/____/____

FOR FDL USE ONLY

VISION SERVICE PLAN ENROLLMENT CARD

- -

PLEASE PRINT Employee's Name (Last, First, Middle Initial)

Employee's Social Security #

Street Address

City

State

Zip

Sex Male
 Female

/ /
Date of Birth

Employer

Job Location

/ /
Hire Date

Coverage Status:

- Employee Only
- Employee & 1 Dependent
- Employee & All Dependents

LIST ALL DEPENDENTS TO BE COVERED BELOW

		LAST NAME (IF DIFFERENT)	FIRST	MI	DATE OF BIRTH			
					MO	DAY	YR	
1	SPOUSE							
2	CHILD							
3	CHILD							
4	CHILD							
5	CHILD							

Add others if necessary.

25M
2/93

Signature _____

Date _____

GROUP DENTAL BENEFIT PLAN ENROLLMENT FORM

PLEASE PRINT

EMPLOYER: OCCUPATION _____ DEPT _____ LOCATION _____ DATE EMPLOYED ____/____/____

SOCIAL SECURITY # _____ LAST NAME _____ FIRST _____ MI _____ SEX M F _____ BIRTH DATE ____/____/____ EMPLOYEE PHONE # _____ (____) _____

EMPLOYEE'S HOME ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP) _____

MARITAL STATUS: (CHECK APPROPRIATE BOXES) AND FURNISH DATE) NEVER MARRIED MARRIED ____/____/____ WIDOWED ____/____/____

LEGAL SEPARATION ____/____/____ DIVORCED* ____/____/____ REMARRIAGE ____/____/____

* IF EVER DIVORCED AND ENROLLING DEPENDENTS, PLEASE PROVIDE A COPY OF THE PORTION OF ANY DIVORCE DECREE(S) REFERRING TO CUSTODY AND RESPONSIBILITY FOR HEALTH EXPENSES OF ANY DEPENDENTS DIRECTLY TO CoreSource, Inc. BE SURE TO INCLUDE YOUR NAME, SOCIAL SECURITY NUMBER AND EMPLOYER NAME WITH THE DECREE. ELIGIBILITY FOR YOUR DEPENDENTS CANNOT BE DETERMINED AND CLAIMS WILL NOT BE CONSIDERED FOR PAYMENT UNTIL YOU HAVE RETURNED THE REQUESTED INFORMATION.

TYPE OF COVERAGE: (CHECK ONE) INDIVIDUAL (EMPLOYEE ONLY) EMPLOYEE PLUS ONE EMPLOYEE PLUS TWO NO COVERAGE

FAMILY (EMPLOYEE & ELIGIBLE DEPENDENTS)

IF NO COVERAGE HAS BEEN SELECTED, I HEREBY REFUSE THE BENEFIT PLAN OFFERED BY MY EMPLOYER AND UNDERSTAND THAT MY FUTURE ENROLLMENT MAY BE SUBJECT TO CERTAIN RESTRICTIONS OR REQUIREMENTS AS DEFINED BY THE PLAN.

ARE YOU, YOUR SPOUSE EMPLOYED? CHECK: YES NO

ARE YOU, YOUR SPOUSE OR DEPENDENTS COVERED UNDER ANY OTHER DENTAL PLAN? IF YES, WHO IS COVERED, PLAN NAME, NAME & ADDRESS OF INSURANCE CO., EFFECTIVE DATE OF COVERAGE CHECK: YES NO

LIST OF DEPENDENTS:

DEP. #1	DEP. #2	DEP. #3	DEP. #4	DEP. #5
FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS FRAUD WHICH IS A CRIME.

I HEREBY CONSENT AND AUTHORIZE ANY DENTIST, PHYSICIAN, SUPPLIER, HOSPITAL, PHARMACY, INSURANCE COMPANY, EMPLOYER OR ORGANIZATION TO DISCLOSE ANY INFORMATION REGARDING THE MEDICAL RECORDS CONCERNING MYSELF OR A MEMBER OF MY FAMILY TO CoreSource, Inc. FOR THE PURPOSE OF SUPERVISING AND MONITORING THE HEALTH PLAN(S). THIS CONSENT SHALL BE VALID UNTIL REVOKED IN WRITING BY THE EMPLOYEE.

TO BE COMPLETED BY EMPLOYER

EFFECTIVE DATE _____

REASON: _____

DATE CHANGE OCCURRED: _____

EMPLOYEE SIGNATURE _____ DATE _____

NEW ENROLLMENT RE-ENROLLMENT NAME CHANGE - FORMERLY

REINSTATEMENT OPEN ENROLLMENT CHANGE DEPENDENT STATUS:

CANCELLATION ADDRESS CHANGE