

Fort Dearborn Life **Group Life/AD&D Coverage Issuance Instructions**

Thank you very much for your interest in applying for coverage with Fort Dearborn Life Insurance Company (FDL). We trust you will find the proposed Group Life and AD&D coverage a valuable addition to your client's benefits portfolio.

The instructions below are designed to make installation of this coverage as quick and easy as possible. Also included are the documents which are referenced and are needed to provide coverage for your client.

For Groups of 10-50 Eligible Employees

In order to make installation of the Life/AD&D program a smooth process, please include the following:

- A check for the first premium payment made out to "Fort Dearborn Life Insurance Company". If your total monthly premium is less than \$100, billing will be done quarterly. Therefore, the first premium payment will be for three months of premium
- An "Application for Group Insurance" (FDL9-516-705(NJ)), signed by an officer of the proposed policyholder
- A completed enrollment form (9-553-206(NJ)), or complete census listing, (including first/last name, gender, DOB, DOH and SS#) for each employee requesting coverage (Copies of the current carrier's enrollment forms are acceptable).
- A copy of the proposal must accompany your submission.

Product and Coverage Options

If your client's current plan design differs from the quoted flat benefit amounts or if your customer has additional products needed, we can still provide you with a quote.

In addition to Group Life benefits Fort Dearborn Life currently offers

- Long Term Disability
- Voluntary Life
- Voluntary Long Term Disability

Please send the details of your customers needs including census to Jessica_Kudryk@horizonblue.com for consideration.

Payment of Commissions

You will receive commissions through your Master Broker. At time of submission, please indicate the Master Broker you are working with. Once again, we thank you for your interest in Fort Dearborn's Life/AD&D product.

Submit paperwork to:

Horizon Healthcare Insurance Agency
3 Penn Plaza East, PP-09T
Newark, NJ 07105-2200

Questions

Jessica_Kudryk@horizonblue.com
PH# 973-466-6493
FAX# 973-274-2275



PRODUCTS APPLYING FOR (check all that apply): **GROUP #:** _____

Group Term Life/AD&D, Supplemental Life/AD&D, Dependent Life (**Please complete Sections I, II, III & V**)

Group Short Term Disability (**Please complete Sections I, II, III & V**)

Group Long Term Disability (**Please complete Sections I, II, IV & V**)

I. APPLICANT INFORMATION Please Type Or Print All Information

Policyholder (correct legal name) _____
 Mailing Address (not P.O. Box) _____
 Address _____
 City _____ State _____ ZIP _____
 Phone () _____ Fax () _____
 Group Contact _____
 Email Address _____

Subsidiaries or Affiliates?: Yes No (If more than one, indicate on separate sheet.)
 If Yes: Company Name _____
 Address _____

Will they be billed separately: Yes No (If separate bills are desired, list address of subsidiaries or affiliates on a separate sheet.)

Nature of Business	SIC Code	Effective Date 12:01 a.m.	First Anniversary
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W-2 Information: A W-2 Agreement must be completed and attached to this Application for all groups with Disability coverage.

II. GENERAL INFORMATION

Contributions: Employer will contribute: Group Life/AD&D <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Dependent Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Supp. Life/AD&D <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % STD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % LTD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %		Check if applicable: <input type="checkbox"/> Partnership <input type="checkbox"/> Subchapter S Corp. <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation			
Waiting Period: <input type="checkbox"/> None <input type="checkbox"/> First of month following completion of _____ Days <input type="checkbox"/> Other _____	Waiting Period applies to: <input type="checkbox"/> All employees <input type="checkbox"/> New employees only				
Participation Requirements for Group Products: 75% – Contributory (excludes Supp. Life & Dep. Life) 100% – Noncontributory					
	Group Life/AD&D	Supplemental Life/AD&D	Dependent Life	STD	LTD
Total eligible employees	_____	_____	_____	_____	_____
Total enrolled	_____	_____	_____	_____	_____
Initial Rates Guaranteed Life/AD&D: for _____ months STD: for _____ months LTD: for _____ months	Premium Payable: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually		Premium is due on the _____ day of each billing period.		
Billing Method: <input type="checkbox"/> List Billed <input type="checkbox"/> Web Billing <input type="checkbox"/> Self-Administered <input type="checkbox"/> TPA Billed					
Premium Deposit: \$ _____ (approx. one month's premium)					
FOR GROUPS OF 100 + ONLY Form 5500, Schedule A <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, benefit plan year is: _____ Account information should be sent to: _____					



III: SCHEDULE OF BENEFITS

ELIGIBLE CLASSES - DESCRIBE BELOW

Class 1 _____
 Class 2 _____
 Class 3 _____
 Class 4 _____

All active employees who work at least _____ hours per week are eligible for coverage. If blank, 30 hours per week will apply.

SELECTION OF COVERAGE(S) (fill in all applicable blanks)

Class	Group Life Insurance Amount of Insurance	AD&D Principal Sum	Supplemental Life Amount of Insurance	Supplemental AD&D Principal Sum	Short-Term Disability Maximum Weekly Benefit
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____

- Weekly STD benefit is subject to a maximum of _____% of employee's basic weekly wage.
- STD Benefits Payable: _____ day of Accident _____ day of Sickness for a maximum of: _____ weeks
 1st day Hospital? Yes No
 Minimum Weekly Benefit (if applicable) _____
 Working Partial Disability Benefit Option Yes No Partial Disability Benefit Option Yes No
- Is Supplemental Life coverage portable? Yes No
- Is this policy replacing an existing policy? Yes No
 (If yes, a copy of prior carrier's plan is required for claims administration)
 Previous Company _____ Termination Date Of Prior Plan _____

Dependent Life Insurance (Benefit amounts are limited in some states)

Spouse: _____ \$ _____
Child(ren): (select one) from live birth to 6 months from 15 days to 6 months \$ _____
 (select one) 6 months to 19 years* 6 months to age _____* \$ _____
 (select one) Other: _____ to age _____* \$ _____
 * To age _____ if full-time student(s) and dependent upon the insured for support.

GENERAL PROVISIONS (fill in all applicable blanks)

- Life and AD&D benefits include 24-hour coverage.
- If the Life and AD&D benefit is a multiple of salary, amount should be rounded to:
 the next higher the next lower the nearest multiple of \$ _____.
- Earnings for calculating STD 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 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.
- Group Life and AD&D benefits reduce by: 35% of the original amount at age 65, and further reduce to 50% at age 70.
 _____% of the original amount at age _____, and to _____% at age _____, and to _____% at age _____.
- Supplemental Life and AD&D benefits reduce by _____% of the original amount at age _____, and to _____% at age _____, and to _____% at age _____.
- STD Benefits payable for non-occupational disabilities only.
- All benefits terminate at retirement unless otherwise noted in class definitions section.

GUARANTEE ISSUE (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)

Life: Group \$ _____ *Supplemental \$ _____ *Combined Group and Supplemental \$ _____
STD: \$ _____ *Based upon a min. participation of _____%



IV. LONG TERM DISABILITY

1. ELIGIBLE CLASSES - DESCRIBE BELOW		
Class 1 _____ Class 2 _____ Class 3 _____ Working a minimum of _____ regularly scheduled hours per week. If blank, 30 hours per week will apply.	2. Prior Employment to Count for People Rehired Within 6 Months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Is this policy replacing an existing policy?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Carrier _____ (a copy of prior carrier's plan is required for claims administration) Termination Date: _____		
4. Elimination Period: <input type="checkbox"/> 90 days Class _____ <input type="checkbox"/> 180 days Class _____ <input type="checkbox"/> Other _____ Class _____	5. Maximum Monthly Benefit: (If other than below, indicate on separate sheet) Class I: _____% of monthly earnings, up to a maximum of \$ _____ Class II: _____% of monthly earnings, up to a maximum of \$ _____ Class III: _____% of monthly earnings, up to a maximum of \$ _____	
6. Definition of Monthly Earnings will include (check all that apply): <input type="checkbox"/> No commission or bonuses <input type="checkbox"/> Bonuses <input type="checkbox"/> Commissions <input type="checkbox"/> W-2 <input type="checkbox"/> Other _____	7. Social Security Offset Method: <input type="checkbox"/> Primary & Family <input type="checkbox"/> Primary Only <input type="checkbox"/> 70% All Sources	8. Minimum Benefit: \$ _____ or _____% of gross monthly income, whichever is greater.
9. Pre-Existing Condition Limitation: <input type="checkbox"/> 3/12 <input type="checkbox"/> 3/6/12 <input type="checkbox"/> Other _____	10. Maximum Period Payable: <input type="checkbox"/> Reducing Benefit Duration (ADEA-1) <input type="checkbox"/> Social Security Normal Retirement Age <input type="checkbox"/> 65/5/70 (ADEA-3) <input type="checkbox"/> Other _____	11. Own Occupation: <input type="checkbox"/> 24 months Class _____ <input type="checkbox"/> 36 months Class _____ <input type="checkbox"/> Other _____ Class _____
12. Partial Disability: <input type="checkbox"/> 80%/60% (24 months/thereafter) <input type="checkbox"/> 80%/80% (24 months/thereafter) <input type="checkbox"/> 60%/60% (24 months/thereafter) Pre-Disability Earnings Indexed? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Work Incentive Benefit/ Rehabilitation Incentive Income Calculation Method: <input type="checkbox"/> Proportionate Loss <input type="checkbox"/> 50% Offset	
14. Indicate Benefits Selected - Please check "Yes" or "No" for each option:		
A. <input type="checkbox"/> Yes <input type="checkbox"/> No Worksite Modification <input type="checkbox"/> \$1,500 <input type="checkbox"/> _____	F. <input type="checkbox"/> Yes <input type="checkbox"/> No COLA (Lesser of Pct. or CPI.) <input type="checkbox"/> 3% <input type="checkbox"/> _____ No. of Adjustments _____	
B. <input type="checkbox"/> Yes <input type="checkbox"/> No Education <input type="checkbox"/> \$300 <input type="checkbox"/> _____	G. <input type="checkbox"/> Yes <input type="checkbox"/> No Accidental Dismemberment Benefit	
C. <input type="checkbox"/> Yes <input type="checkbox"/> No Survivor Income Benefit <input type="checkbox"/> 3 times <input type="checkbox"/> _____ last monthly benefit Benefit Payable <input type="checkbox"/> Lump Sum <input type="checkbox"/> Monthly	H. <input type="checkbox"/> Yes <input type="checkbox"/> No Catastrophic Disability Benefit Pct. <input type="checkbox"/> 10% <input type="checkbox"/> _____ Maximum <input type="checkbox"/> \$5,000 <input type="checkbox"/> _____ Elimination Period <input type="checkbox"/> 180 days <input type="checkbox"/> _____ Benefit Duration <input type="checkbox"/> 12 months <input type="checkbox"/> _____	
D. <input type="checkbox"/> Yes <input type="checkbox"/> No Family Income Benefit Pct. <input type="checkbox"/> 66 2/3% <input type="checkbox"/> _____ Benefit Duration <input type="checkbox"/> 1 year <input type="checkbox"/> _____	I. <input type="checkbox"/> Yes <input type="checkbox"/> No Rehabilitation Benefit Benefit Pct. <input type="checkbox"/> 5% <input type="checkbox"/> _____ Maximum <input type="checkbox"/> \$500 <input type="checkbox"/> _____	
E. <input type="checkbox"/> Yes <input type="checkbox"/> No Terminal Illness Benefit <input type="checkbox"/> 3 times <input type="checkbox"/> _____ last monthly benefit	J. <input type="checkbox"/> Yes <input type="checkbox"/> No Retirement Plan Protection Benefit Pct <input type="checkbox"/> 6% <input type="checkbox"/> _____ Maximum <input type="checkbox"/> \$2,500 <input type="checkbox"/> _____	
15. Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Disorder <input type="checkbox"/> 24 months <input type="checkbox"/> Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Substance Abuse <input type="checkbox"/> 24 months <input type="checkbox"/> Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Lifetime Cumulative Maximum of _____ months.		



V: 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:

1. 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;
2. Make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. Maintain records and furnish FDL or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. Provide notice of life insurance conversion rights to eligible employees and eligible dependents;
5. 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;

Further the undersigned agrees that:

6. Claims filed by or on behalf of employees for a loss incurred after the end of the grace period, 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 issuance of 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 Sections III and/or IV; 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 contracts and/or policies to the employer, 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 who includes false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

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
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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"/> Weekly <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 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 FIRST M.I. (if applicant)	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 STD and LTD**

- 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.
- Your Voluntary LTD benefit 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.

YOU MUST COMPLETE BOTH PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.



Employee Name: _____ **Social Security #:** _____

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 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 files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties. (For New Jersey residents only.)

EMPLOYEE SIGNATURE _____ DATE ____ / ____ / ____

FOR FDL USE ONLY
