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 2-9 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.
- A "Participation Agreement" (Form # G-68-305), signed by an officer of the proposed policyholder
- A completed enrollment form (Form #9-553-206 (NJ)) for each employee requesting coverage
- 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

Fort Dearborn Life Insurance Company
Administrative Offices: Downers Grove, Illinois | Cleveland, Ohio | Dallas, Texas

Participation Agreement
Please Type or Print All Information

I: APPLICANT INFORMATION

Employer Name (correct legal name) ____

Mailing Address (not P.O. Box) ____

City ______________________ State ______________ Zip Code ________

Group Contact ______________________ Phone (   )__________ Email Address: ______________

SIC Code / Nature of Business
________ / ____________________

Effective Date

Contributions: Employer will contribute: (Minimum of 25%)

☐ Life/AD&D	☐100%	☐Other _________ %
☐ Dependent Life	☐100%	☐Other _________ %
☐ Short Term Disability	☐100%	☐Other _________ %
☐ Long Term Disability	☐100%	☐Other _________ %

Coverage Applying for: (Select one)

- ☐ Life/AD&D
- ☐ Life/AD&D/Dependent Life
- ☐ Life/AD&D/Short Term Disability
- ☐ Life/AD&D/Short Term Disability/Dependent Life
- ☐ Life/AD&D/Long Term Disability
- ☐ Life/AD&D/Long Term Disability/Dependent Life
- ☐ Life/AD&D/Short Term Disability/Long Term Disability
- ☐ Life/AD&D/Short Term Disability/Long Term Disability/ Dependent Life
- ☐ Short Term Disability/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:
☐ All Employees ☐ New Employees Only

Waiting Period: ☐ First of the month following completion of 30 Days
☐ First of the month following completion of ___ Days (minimum of 30 days)

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: Quarterly
☐ If a monthly premium payable cycle is preferred. (Monthly premium must be greater than $100).

W-2 Information: A W-2 Agreement must be completed and attached to this Participation Agreement if disability coverage is purchased.

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

☐ Life/AD&D Insurance

		Flat Benefit Amount:	Annual Salary Based :	Minimum Benefit:	Maximum Benefit:
Class 1	____________________	$ __________	☐ 1x ☐ 2x ☐ 3x	$ __________	$ __________
Class 2	____________________	$ __________	☐ 1x ☐ 2x ☐ 3x	$ __________	$ __________
Class 3	____________________	$ __________	☐ 1x ☐ 2x ☐ 3x	$ __________	$ __________

(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) $ 100 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 Maximum: $250.00	Percent of Weekly Income:	Maximum Benefit:
Class 1	______________	$ __________	☐ 50% ☐ 60% ☐ 66 2/3%	$ __________
Class 2	______________	$ __________	☐ 50% ☐ 60% ☐ 66 2/3%	$ __________
Class 3	______________	$ __________	☐ 50% ☐ 60% ☐ 66 2/3% (All classes must use same benefit percent)	$__________ (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)

Class 1 ☐ **Long Term Disability**
Offered to 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

1. Life and AD&D benefits include 24-hour coverage.
2. If the Life and AD&D benefit is a multiple of salary, amount will be rounded to the next higher multiple of $1,000, if not already a multiple.
3. 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.
4. 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.
5. STD Benefits payable for non-occupational disabilities only, except where prohibited by law.
6. 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:

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 applicable 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 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 ______________________

FORT DEARBORN LIFE Insurance Company

ENROLLMENT FORM

Chicago, Illinois **Administrative Office:** Downers Grove, Illinois | Cleveland, Ohio | Dallas, Texas

EMPLOYER: If group is self-administered, submit enrollment for only if evidence of is required. If group is not self administered, submit enrollment for m 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.**

BASIC COVERAGE(S)				Supplemental Life	Supplemental AD&D	Other________
Basic Life/AD&D ☐ YES ☐NO	**STD Benefit** ☐YES ☐NO	**LTD Benefit** ☐YES ☐NO	**Dependent Life** ☐YES ☐NO	☐Add ☐Change ☐ Del. $ _______	☐Add ☐Change ☐Del. $_______	☐Yes ☐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 ☐ YES ☐ NO			
Voluntary Term Life: Spouse ☐ YES ☐ NO			
Voluntary Term Life: Dependent Child(ren) ☐ YES ☐ NO			
Voluntary AD&D: ☐ Individual Plan ☐ Family Plan ☐ NO			
Voluntary Long-Term Disability - Incremental ☐ YES ☐ NO			
Voluntary Long-Term Disability - % of Salary ☐ YES ☐ NO			

SPOUSE NAME-LAST (if applicant) FIRST M.I.	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 a scheduled enrollment period.
- 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.

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

FORT DEARBORN LIFE *Insurance Company*

ENROLLMENT FORM

Chicago, Illinois **Administrative Office:** Downers Grove, Illinois | Cleveland, Ohio | Dallas, Texas

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 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.
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.)

FOR FDL USE ONLY

EMPLOYEE SIGNATURE ____ DATE _____/_____/______