



VOLUNTARY

APPLICANT INFORMATION Please Type Or Print All Information

Policyholder (Employer - correct legal name) _____ Mailing Address (not P.O. Box) _____ Physical Address _____ Phone () _____ Fax () _____ Group Contact _____ Email Address _____ Name of any Affiliates, Subsidiaries, or Divisions to be covered _____ IF SEPARATE BILLS ARE DESIRED, LIST ADDRESSES OF SUBSIDIARIES OR AFFILIATES ON A SEPARATE SHEET.	Group Effective Date: _____
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GENERAL INFORMATION (Please type or print all information)

Contributions: Employer will contribute: Employees: <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Dependents: <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %	Waiting Period applies to: <input type="checkbox"/> All employees <input type="checkbox"/> New employees only <input type="checkbox"/> None <input type="checkbox"/> Following completion of _____ Days <input type="checkbox"/> Premium Due Date following _____ Days <input type="checkbox"/> Other _____
Participation: Total eligible employees _____ Total enrolled _____	Initial Rates Guaranteed for _____ months Annual Enrollment: <input type="checkbox"/> Yes <input type="checkbox"/> No Premium is due on the _____ day of each billing period.
Premium Payable: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually	Billing Method: <input type="checkbox"/> List Billed <input type="checkbox"/> On-line Web Billing <input type="checkbox"/> Self-Administered <input type="checkbox"/> TPA Billed
Premium Deposit: \$ _____ (approx. one month's premium)	

Does this coverage replace existing dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is prior carrier plan and billing history information being provided? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Information being provided from prior carrier: Deductible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other – Specify _____ Orthodontic Services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other – Specify _____ Temporomandibular Joint (TMJ) Services <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other – Specify _____ Annual Maximum <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other – Specify _____

Please complete the section below for groups with eligible employees between 10 and 25 lives.

Eligible Classes – Describe below and select one Plan per Class.		
<u>Description</u>	<u>Plans</u>	
Class 1 _____	<input type="checkbox"/> PPO Gold	<input type="checkbox"/> PPO Silver <input type="checkbox"/> PPO Bronze
Class 2 _____	<input type="checkbox"/> PPO Gold	<input type="checkbox"/> PPO Silver <input type="checkbox"/> PPO Bronze
Class 3 _____	<input type="checkbox"/> PPO Gold	<input type="checkbox"/> PPO Silver <input type="checkbox"/> PPO Bronze
Class 4 _____	<input type="checkbox"/> PPO Gold	<input type="checkbox"/> PPO Silver <input type="checkbox"/> PPO Bronze
All active <u>employees</u> who work at least _____ hours per <u>week</u> are eligible for coverage. If hours are not provided, 30 hours per week will apply.		

For Groups with 26 or more eligible employees, please attach the proposed schedule of benefits from the group proposal document.



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. 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:

5. Claims filed by or on behalf of employees may, at FDL's option, be suspended if premiums are not received timely;
6. 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;
7. 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.

8. 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 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;
9. 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;
10. 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;
11. 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 required number of hours and satisfies any other conditions required by the applicable group Policy.
12. The requested coverage is not in effect unless and until this application is accepted by FDL, that acceptance 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 accepted for coverage by FDL.
13. 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 (11) 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 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. (3) I have not signed any of the enrollment forms for a group representative or individual applicant. (4) 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. (5) 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. (6) I am licensed in the state of this group for the types of insurance solicited.

 Print Name

 Signature

 Date



Benefits Manager Registration

Fort Dearborn Life is excited you have chosen to register for the administrative solutions offered through Benefits Manager. Benefits Manager is designed to work with your groups chosen billing method. If you have questions regarding this form or the services available in Benefits Manager, please call customer service at 1-800-348-4512.

This form is to be completed by the Policyholder.

Group Coverage Information: Group # _____ Account # _____

Section I - Benefits Manager Access

I wish to manage my group's enrollment and billing information online in real-time. I acknowledge that I will not receive a regular billing statement from Fort Dearborn Life. I will obtain all invoices, including my remittance page online from Benefits Manager (Web Billing).

I require view-only online capability for my group's coverage, billing and payment information. I wish to still receive a regular billing statement from Fort Dearborn Life (List Billing/Self-Administered paper).

As Policyholder I authorize the employee named below to access group and policy information as stated above via Fort Dearborn Life's Web site (www.fdl-life.com).

Name: _____ Company: _____
Signature: _____ Date: _____

User Information (Please print clearly)

First Name: _____ MI: _____ Last Name: _____
Organization/Company: _____ Phone: () _____ - _____
Mother's Maiden Name: _____ Last Four Digits of SSN: _____
E-mail Address: _____ Signature: _____ Date: _____

Section II - Producer (Agent) Access

As Policyholder:

I authorize Fort Dearborn Life to grant our Producer(s) access to our billing and coverage information via www.fdl-life.com. I understand that this will allow our Producer(s) to view, add, delete or edit employee information pertaining to our policy/or policies on this website.

I do not authorize Producer access to our billing and coverage information via www.fdl-life.com.

Signature: _____ Date: _____
Producer Name: _____ Producer User ID: _____
Producer Name: _____ Producer User ID: _____

For FDL Office Use Only - To be completed by a Fort Dearborn Life employee.

Group Administrative Services:

Web Billing/Administrative Solutions (Web Billing)

Administrative Solutions Only (List or Self-Administered Billing)

Multi-Group User

Role Required: Group Administrator

List subsidiaries/affiliates which will be administered by the above Benefit Administrator, if applicable.

Login ID (6 character maximum)	Group ID
FDL.GRP.	

Fort Dearborn Life will treat this information as confidential and will restrict access to the information as permitted by law, such as disclosures to our affiliates, agents, administrators, consultants and regulatory or governmental authorities, or as necessary to administer our Web sites and the insurance coverage's provided your Company.