



**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<br>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<br>\$        | <input type="checkbox"/> Weekly<br><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<br><input type="checkbox"/> YES <input type="checkbox"/> NO | STD Benefit<br><input type="checkbox"/> YES <input type="checkbox"/> NO | LTD Benefit<br><input type="checkbox"/> YES <input type="checkbox"/> NO | Dependent Life<br><input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del.<br>\$ _____ | <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Del.<br>\$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No<br>\$ _____ |

| VOLUNTARY COVERAGE(S) (Evidence of Insurability may be required on employee and spouse Life and Critical Illness Insurance) | (A)dd<br>(C)hange<br>(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 - Incremental <input type="checkbox"/> YES <input type="checkbox"/> NO                      |                               |                                      |                               |
| Voluntary Short-Term Disability - % of Earnings <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 Earnings <input type="checkbox"/> YES <input type="checkbox"/> NO                     |                               |                                      |                               |

|                                      |       |      |  |                      |                          |
|--------------------------------------|-------|------|--|----------------------|--------------------------|
| SPOUSE NAME — LAST<br>(if applicant) | FIRST | M.I. | SEX<br>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.
- 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 and/or Voluntary STD 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 injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

FOR FDL USE ONLY



# Evidence of Insurability Application (EOI)

Administrative Offices: Downers Grove, Illinois | Cleveland, Ohio | Dallas, Texas

**PART 1: TO BE COMPLETED BY GROUP ADMINISTRATOR/EMPLOYER** (Please Print and submit with copy of employee enrollment form)

|  |   | FOR FDL USE ONLY  |   |   |
|--|---|---|---|---|
| Group Number _____   | Group Name and Address<br><br><br><br>Group Contact _____<br>(Print Name)<br><br>Group Contact _____<br>(Print Title)<br><br>Telephone (____) _____<br><br>Fax (____) _____ | <b>EMPLOYEE</b><br><input type="checkbox"/> Approved<br><input type="checkbox"/> Declined<br><input type="checkbox"/> Closed<br><input type="checkbox"/> Smoker<br><input type="checkbox"/> Nonsmoker | <b>SPOUSE</b><br><input type="checkbox"/> Approved<br><input type="checkbox"/> Declined<br><input type="checkbox"/> Closed<br><input type="checkbox"/> Smoker<br><input type="checkbox"/> Nonsmoker | <b>CHILD(REN)</b><br><input type="checkbox"/> Approved<br><input type="checkbox"/> Declined<br><input type="checkbox"/> Closed<br><br>Amount Approved<br>\$ _____<br>Effective Date*<br>_____ |
| Group Contact _____<br>(Print Name)  |   | GI <input type="checkbox"/> No <input type="checkbox"/> Yes<br>\$ _____   | GI <input type="checkbox"/> No <input type="checkbox"/> Yes<br>\$ _____   | Reviewed by & date<br>_____   |
| Group Contact _____<br>(Print Title)   |   | Amount Approved<br>\$ _____   | Amount Approved<br>\$ _____   | State Code _____<br><br>Agency (CB)(TPA)<br>_____   |
| Telephone (____) _____   |   | Effective Date*<br>_____  | Effective Date*<br>_____  | <input type="checkbox"/> SAWEB<br><input type="checkbox"/> Self-Admin<br><input type="checkbox"/> Direct Bill _____   |
| Fax (____) _____   | <b>Reason for EOI:</b><br><input type="checkbox"/> Amount over Guarantee Issue<br><input type="checkbox"/> Late Enrollment<br><input type="checkbox"/> Other _____          | If New Hire, Indicate Eligibility Waiting Period<br>_____<br><br>Policy Anniversary Date<br>_____   | Reviewed by & date<br>_____   | Reviewed by & date<br>_____   |
| * The effective date of coverage is the date the application is approved. Premium is due the first of the month following the approval date.<br><b>Do not deduct premiums for any coverage subject to evidence of insurability until you receive FDL's final confirmation of approval.</b> |   |   |   |   |

**PART 2: TO BE COMPLETED BY EMPLOYEE** - This section contains essential information and leaving any item blank will cause a delay in processing your insurance request.

**EMPLOYEE**

|                               |      |       |        |               |                |   |                |
|-------------------------------|------|-------|--------|---------------|----------------|---|----------------|
| Name                          | Last | First | M.I.   | Date of Birth | Age            | Sex   | State of Birth |
|                               |      |       |        | / /           |                | <input type="checkbox"/> M <input type="checkbox"/> F |                |
| Home Mailing Address - Street |      | City  | State  | Zip           | Work Telephone | Home Telephone  |                |
|                               |      |       |        |               | ( )            | ( )   |                |
| Social Security #             |      |       | Height | ft.           | in.            | Weight  | lbs.           |

**SPOUSE** - DO NOT complete spouse information unless you are applying for dependent spouse coverage.

|                   |      |       |        |               |     |   |                |
|-------------------|------|-------|--------|---------------|-----|---|----------------|
| Name              | Last | First | M.I.   | Date of Birth | Age | Sex   | State of Birth |
|                   |      |       |        | / /           |     | <input type="checkbox"/> M <input type="checkbox"/> F |                |
| Social Security # |      |       | Height | ft.           | in. | Weight  | lbs.           |

**CHILD(REN)** - DO NOT complete this section unless you are applying for dependent child(ren) life insurance which is subject to satisfactory evidence of insurability (for example, a late enrollment.) *Evidence of insurability is not required for voluntary dependent child term life coverage.*

| Dependent Child Full Name | SS# | Date of Birth | Age | Sex   | Ht & Wt |
|---------------------------|-----|---------------|-----|---|---------|
|                           |     |               |     | <input type="checkbox"/> M <input type="checkbox"/> F |         |
|                           |     |               |     | <input type="checkbox"/> M <input type="checkbox"/> F |         |
|                           |     |               |     | <input type="checkbox"/> M <input type="checkbox"/> F |         |

**YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION IN ORDER TO BE CONSIDERED FOR COVERAGE.**  
Retain a copy for your records.



**Part 3: Health Information (Answer all questions fully, accurately, and truthfully for any person applying for coverage.)**

| Check either "Yes" or "No" to each question and circle the specific condition(s). Details to all "yes" answers must be provided below. Failure to provide full information or providing false information may result in denial of benefits and/or possible investigation for fraud.   | Employee                     |                             | Spouse                       |                             | Child(ren)                   |                             |
|---|------------------------------|-----------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
|   | Yes                          | No                          | Yes                          | No                          | Yes                          | No                          |
| 1. Has any person applying for coverage been seen, treated, advised or received services from any health provider <u>in the last 12 months</u> , including routine physicals?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Within the last 7 years, to the best of your knowledge and belief, <b>has any person applying for coverage been diagnosed with and/or received treatment, by a licensed physician for any of the following:</b>  |                              |                             |                              |                             |                              |                             |
| a. High blood pressure, heart attack, chest pain, shortness of breath, irregular heartbeat, murmur, coronary artery disease, heart surgery (catheterization/angioplasty/bypass, etc.), or any other disease or disorder of the heart or circulatory system?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Enlarged glands, thyroid disorder, diabetes, abnormal glucose level, hepatitis, cirrhosis, abnormal liver studies, hernia, ulcer, colitis or any other disease or disorder of the liver, endocrine, or digestive system?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Alcohol and/or drug abuse/addiction/treatment, depression, anxiety, bipolar, ADD/ADHD, anorexia, bulimia or any other mental/nervous/behavioral disorder?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Asthma, emphysema, tuberculosis, pneumonia, COPD, sleep apnea, or any other disease or disorder of the throat, lungs, or respiratory tract?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Prostate, uterus/tubes/ovaries, endometriosis, cystitis, kidney stone, renal failure, sexually transmitted diseases, any disorder of the kidneys/bladder/urinary tract, breast lumps/changes/biopsies, abnormal test results or any other male/female disorder?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Cancer, tumor, cyst, moles, polyps, growth or any skin disorder (indicate location and if benign/malignant)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Stroke, paralysis, convulsions, seizures, epilepsy, fainting, headaches, dizziness, or any other disease or disorder of the nervous system?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Arthritis, gout, rheumatism, neck or back strain/sprain/injury, deformity, loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. With in the past 5 years have you been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Does any person applying for coverage currently take medication (prescription or otherwise), been prescribed medication, or has any person done so <u>in the last 6 months</u> ?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. <u>Within the last 2 years</u> , to the best of my knowledge and belief, has any person applying for coverage had a physical disability, surgery, or been confined to a hospital, skilled nursing or rehabilitation facility, undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, MRI, CAT Scans, PET or CT Scans, biopsies, blood or urine tests; or had any medical advice, examination, treatment; and/or been advised of future surgery, treatment, therapy, hospitalization, testing or evaluation to be performed, not mentioned in questions 1 through 3? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Is any person applying for coverage <u>currently</u> pregnant? If "Yes", indicate anticipated delivery date _____. <b>Provide details of any current/prior complications on Page 3.</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Has any person applying for coverage been diagnosed with, and/or received treatment from a licensed physician for <b>ANY</b> reason other than those listed in items 2-6 above?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |





Employee Name \_\_\_\_\_ Social Security # \_\_\_\_\_

No premiums may be deducted on amounts subject to evidence of insurability until a final decision regarding approval of coverage is received by your employer from Fort Dearborn Life.

**AGREEMENTS AND AUTHORIZATION:** I, the undersigned applicant(s), have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand Fort Dearborn Life Insurance Company<sup>®</sup> (FDL) shall not be liable for any claim arising prior to the date of approval of this application at FDL's Home Office.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, clinic or other medical or medically-related facility, medical provider, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL's underwriting department or its authorized representative(s) my medical records, or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to drug or alcohol use or abuse, mental illness, or sexually transmitted diseases.

I further authorize FDL to disclose the information obtained in the consideration of my application for insurance to its reinsurers and, with the exception of information regarding specific HIV test results, to the MIB Group, Inc. a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation;
- Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the HIPAA Privacy Rule;
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- Coverage will not become effective until FDL approves my application, provided that I am actively at work on that day.

I as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from FDL.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, FDL has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

**WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

\_\_\_\_\_  
 Signature of Employee \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Spouse (if requesting insurance) \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Dependent Child (if to be insured and of age of majority) \_\_\_\_\_  
 Date



*(Please retain with your insurance records)*

Thank you for enrolling for Group Insurance with Fort Dearborn Life Insurance Company<sup>®</sup>. To assist us in processing the group policy, your signature on the Agreements and Authorization section of the Evidence of Insurability form authorizes information concerning proposed insureds to be released relative to each person's insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Fort Dearborn Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization, of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply each company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston MA 02112, telephone number 866-692-6901 (TTY 866-346-3642).

Fort Dearborn Life Insurance Company, its reinsurers, or designated representative(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.