

<input type="checkbox"/> New Application <input type="checkbox"/> Change*	*To add benefits or change your group insurance program, complete the items in Sections 1 and 2 marked with an *, the appropriate Schedule of Benefits section(s) and Section 5.	Group #: _____
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Section 1: APPLICANT INFORMATION Please Type Or Print All Information

*Policyholder (correct legal name) _____ Mailing Address _____ Address (not P.O. Box) _____ City _____ State _____ ZIP _____ *Phone () _____ *Fax () _____ *Group Contact _____ *Email Address _____ Check if applicable: <input type="checkbox"/> Partnership <input type="checkbox"/> Subchapter S Corp. <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation Subsidiaries, Affiliates or Divisions to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No (If more than one, indicate on separate sheet.) If Yes: Company Name _____ Address _____ Will they be billed separately? <input type="checkbox"/> Yes <input type="checkbox"/> No (If separate bills are desired, list address of subsidiaries or affiliates on a separate sheet.)				
Nature of Business	# Years in Business	SIC Code	Effective Date 12:01 a.m.	First Anniversary
* Annual Enrollment Period for Contributory Coverages, if applicable: _____				

Section 2: GENERAL INFORMATION

*Product Choice (check all that apply)	Complete Sections	*Employer will contribute	*Total Eligible	*Total Enrolled	Initial Rate Guarantee
<input type="checkbox"/> Group Term Life & AD&D	1, 2, 3, 5	<input type="checkbox"/> 100% <input type="checkbox"/> Other _____%			_____ months
<input type="checkbox"/> Supplemental Term Life & AD&D	1, 2, 3, 5	<input type="checkbox"/> 100% <input type="checkbox"/> Other _____%			_____ months
<input type="checkbox"/> Group Dependent Term Life	1, 2, 3, 5	<input type="checkbox"/> 100% <input type="checkbox"/> Other _____%			_____ months
<input type="checkbox"/> Voluntary Term Life	1, 2, 3, 5	<input type="checkbox"/> 100% <input type="checkbox"/> Other _____%			_____ months
<input type="checkbox"/> Voluntary Term Life & AD&D	1, 2, 3, 5	<input type="checkbox"/> 100% <input type="checkbox"/> Other _____%			_____ months

Eligibility Waiting Period for: <input type="checkbox"/> All employees <input type="checkbox"/> New employees only <input type="checkbox"/> None <input type="checkbox"/> First of month following completion of _____ days <input type="checkbox"/> Premium due date following _____ days <input type="checkbox"/> Other _____	Premium Payable on the _____ day of each <input type="checkbox"/> Month <input type="checkbox"/> Quarter <input type="checkbox"/> 6-Month or <input type="checkbox"/> 12-Month Period FOR GROUPS OF 100 + ONLY Form 5500, Schedule A <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, benefit plan year: _____ Send Account information to: _____
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Section 3: SCHEDULE OF BENEFITS: GROUP LIFE, AD&D and DEPENDENT LIFE Basic Voluntary

3a. ELIGIBLE CLASSES - DESCRIBE BELOW

1. Class 1 _____ Class 2 _____ Class 3 _____ All active employees who work at least _____ hours per week are eligible for coverage. If blank, 30 hours per week will apply.	2. Prior Employment to Count for Employees Rehired Within <input type="checkbox"/> 90 <input type="checkbox"/> 180 days <input type="checkbox"/> Yes <input type="checkbox"/> No
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3. Will this policy replace an existing policy?: Yes No
 If Yes: Carrier _____ (a copy of prior carrier's plan is required for claims administration)
 Termination Date: _____

3b. SELECTION OF COVERAGE(S) (fill in all applicable blanks)

	<input type="checkbox"/> Basic Group Life Insurance Includes AD&D? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Supplemental Life Amount of Insurance	<input type="checkbox"/> Supplemental AD&D Coverage Amount
Class			
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

Voluntary Term Life Insurance (Dependent Life and AD&D Benefits Included?) Yes No

Term Life and AD&D: All Employees \$10,000 to \$500,000 or by Class as indicated below:

Class 1: Flat Benefit of \$10,000 to \$ _____ or _____ x Annual Earnings to a maximum of \$ _____

Class 2: Flat Benefit of \$10,000 to \$ _____ or _____ x Annual Earnings to a maximum of \$ _____

Class 3: Flat Benefit of \$10,000 to \$ _____ or _____ x Annual Earnings to a maximum of \$ _____

Spouse Term Life: Flat Benefit of \$10,000 to \$500,000 Other \$ _____

Dependent Child Term Life: Employee Choice of \$5,000 or \$10,000 (Age 6 months* to 18 years or 23 if full-time student)
 *Life Benefit is \$100 for child age 15 days to 6 months

Basic and Voluntary Group AD&D Benefit includes Education, Repatriation, Seat Belt and Air Bag Benefits.

Education Benefit <input type="checkbox"/> 3% to a maximum of \$3,000 per year <input type="checkbox"/> _____% to a maximum of \$ _____ per year Maximum Duration: <input type="checkbox"/> 4 years <input type="checkbox"/> Other _____	Seat Belt Benefit <input type="checkbox"/> 10% to a maximum of \$25,000 <input type="checkbox"/> _____% to a maximum of \$ _____
Repatriation Benefit <input type="checkbox"/> \$5,000 <input type="checkbox"/> Other \$ _____	Air Bag Benefit <input type="checkbox"/> 5% to a maximum of \$5,000 <input type="checkbox"/> _____% to a maximum of \$ _____

Additional Group AD&D benefit packages: Select below by indicating "Yes" or "No" for each option and select benefit amount.

AD&D Option: Yes No

Other (describe below)

Basic Dependent Life Insurance Yes No

Spouse: (Spouse benefits limited to amount for which employee is eligible) \$ _____
 Does Spouse include Domestic Partner? Yes No

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 support9

Section 5: AUTHORIZATIONS

The undersigned employer and/or authorized representative hereby request that it be approved for insurance coverage through Fort Dearborn Life Insurance Company of New York (FDLNY). 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 also accepts enrollment under the FDLNY 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 FDLNY 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; and
5. Pay FDLNY 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 FDLNY'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 FDLNY'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 FDLNY except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees. This paragraph does not apply to disability coverages, if elected.
8. In order for FDLNY to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, FDLNY, 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 FDLNY 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. Eligibility requirements include (a) working in the United States of America for the Policyholder or Employer (b) for at least the number of hours set forth in the Class Descriptions of this Application and (c) completion of the Eligibility Waiting Period. Part-time, seasonal and temporary employees are not eligible.
13. 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 the Schedule of Benefits sections; and satisfies any other conditions required by the applicable group Policy.
14. The requested coverage is not in effect unless and until this application is approved by FDLNY, 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 FDLNY. 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.
15. 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 (13) above.

Authorized Signature

Date

Title

Licensed Resident Agent (if required)