Dearborn National®

Underwritten by Fort Dearborn Life Insurance Company®

# Application for Group Insurance

Administrative Offices: **Downers Grove, Illinois I Dallas, Texas**

❑ New Application ❑ Change **Group #:**_____ **Federal Tax ID #:**_____

**Section 1. POLICYHOLDER INFORMATION:** Please Type or Print All Information.

Policyholder (full legal name):_____

Address (not PO box):_____

_____

City:_____ State:_____ ZIP:_____

Subsidiaries or Affiliates to be covered? ❑ Yes; or ❑ No (If more than one, indicate on separate sheet; and attach to this application.)

If Yes: Company Name:_____

Address (not PO box):_____

_____

City:_____ State:_____ ZIP:_____

Premium is payable on the first of the insurance month unless mutually agreed upon by the Policyholder and the insurance company.

**Section 2. GENERAL INFORMATION:**

| **Product Choice** (Check all that apply) | **Policyholder will contribute:** | **Requested Effective:** | ***Replacing Coverage Yes/No:** |
|---|---|---|---|
| ❑ Group Term Life ❑ AD&D: | ❑ 100%; or ❑ Other:____% | ____/____/_____ | _____ |
| ❑ Group Dental: | ❑ 100%; or ❑ Other:____% | ____/____/_____ | _____ |
| ❑ Group Short-Term Disability(STD): | ❑ 100%; or ❑ Other:____% | ____/____/_____ | _____ |
| ❑ Group Long-Term Disability(LTD): | ❑ 100%; or ❑ Other:____% | ____/____/_____ | _____ |
| ❑ Voluntary Term Life ❑ AD&D: | ❑ 0%; or ❑ Other:____% | ____/____/_____ | _____ |
| ❑ Voluntary Group Dental: | ❑ 0%; or ❑ Other:____% | ____/____/_____ | _____ |
| ❑ Voluntary Short-Term Disability(VSTD): | ❑ 0%; or ❑ Other:____% | ____/____/_____ | _____ |
| ❑ Voluntary Long-Term Disability(VLTD): | ❑ 0%; or ❑ Other:____% | ____/____/_____ | _____ |

***Enclose a copy of each in force policy to be replaced.**

**Section 3: POLICYHOLDER STATEMENT:**

The Policyholder or authorized representative (Policyholder) applies for a group insurance policy(s) through Fort Dearborn Life Insurance Company (FDL).

The Policyholder represents and certifies that:

1. This application must be approved in writing by FDL. Issuing the insurance policy is evidence of approval. Coverage for insureds under the group policy is effective when the insured applies and is approved for coverage by FDL. The Policyholder will not collect premium from an insured who requires medical underwriting until FDL approves the insured's application for coverage; and
2. FDL will issue a policy only if FDL decides that the group is an acceptable risk based on FDL's underwriting practices and procedures; otherwise FDL has no liability except to refund premium. The Policyholder must return to individual insureds any part of the premium paid by those insureds; and
3. The premium rates are contingent, based on the accuracy of insured eligibility data given to FDL by the Policyholder. Misstatements on an insured's application or failure by the Policyholder or insured to report new medical information before an insured's effective date of coverage may cause a change to the coverage or premium rate as of the policy effective date; and
4. The Policyholder and insureds are subject to all the policy terms and provisions and trust agreements, if applicable. They may be amended from time to time; and
5. If the Policyholder does not collect or pay premiums by the premium due date, the policy will terminate at the end of the policy's grace period; and
6. Even with the purchase of a disability policy, the Policyholder may be required to buy disability coverage under a state disability benefit act or law; and
7. The Policyholder will: a) send FDL applications of individual insureds prior to the eligibility date; b) give certificates to all insureds; c) report changes in the insured group to FDL; and d) keep records of insured eligibility.
8. The information given and statements made on this application are complete and correct. Misstatements or omissions of information may affect the validity of any insurance policy issued and cause the denial of an otherwise valid claim.
9. Statements made by the Policyholder are representations and not warranties. No statement made by any insured will be used in any contest unless a copy of the instrument containing the statement is or has been given to the insured or, in case of death or incapacity of the insured, to his beneficiary or personal representative.

This application and the payment of premium are consideration for any master policy and certificates issued. This application is part of any insurance policy issued. The authorized signature on this application is acceptance of the policy terms.

| | |
|---|---|
| Authorized Signature | Date (Must be signed prior to Effective Date) |
| Print name and Provide Title | Licensed Resident Agent (if required) |

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# Fraud Notices

Administrative Offices: **Downers Grove, Illinois I Dallas, Texas**

**The laws of some states require us to furnish you with the following notice:**

## FOR APPLICATIONS AND CLAIMS:

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** 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.

**Hawaii:** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

**Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine & Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Maryland:** Any person who knowingly and willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Ohio:** Any person who, with intent to defraud or knowingly that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

**Pennsylvania:** 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 subjects such person to criminal and civil penalties.

**Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee:** It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits

**Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.





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**The laws of some states require us to furnish you with the following notice:**

## FOR CLAIMS ONLY:

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement or claim containing false, incomplete, or misleading information is guilty of a felony.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

## FOR APPLICATIONS ONLY:

**Massachusetts:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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# FICA Tax/W-2 Agreement

**Administrative Offices:** Downers Grove, Illinois I Dallas, Texas
**Dearborn National FICA Withholding@DearbornNational.com**
Fax (312) 946-3564

**Request Effective with Tax Year:** **W-2:** _____ (current or future tax year) **FICA Match:** _____ (New group - current or future tax year) (Existing group - future tax year only)

Employer Name: _____ Telephone Number: _____

Contact Person:_____ Fax Number: _____

Employer Tax ID Number (EIN): _____ E-mail address _____

Group Policy Number(s):_____

**This Agreement Applies to:** ☐ **Short Term Disability Only** ☐ **Long Term Disability Only** ☐ **Both STD and LTD**

**A. W-2 Options for disability income benefits ("sick pay") - Choose Option 1 or Option 2:**

**W-2 Option** may be selected up to November 15th of the current tax year.

☐ **OPTION 1. Insurer prepares W-2 statements for payees and files Federal and State information returns reporting sick pay.**

Employer hereby designates Insurer as its agent for the sole purpose of providing W-2 statements with sick pay information to payees by January 31st of each year, or such other date required by the Internal Revenue Service, and for making information return filings in accordance with Federal and State requirements regarding income tax, social security and Medicare tax. Insurer will use its EIN number on each of these forms. Employer is responsible for providing Insurer with all information necessary for Insurer to file timely and correct statements and returns, including the information necessary to determine the taxable portion of sick pay. The employee contributions made with after tax dollars will determine what portion of sick pay, if any, is excludable from employee's gross income. If Policy terminates, Insurer will continue to provide W-2 statements and make information return filings for sick pay payments on all claims incurred prior to termination of Policy.

**NOTE**: We will issue W-2's on a continuous basis, until notified differently by the Employer.

☐ **OPTION 2. Insurer DOES NOT prepare Form W-2 statements for payees and Federal and State information returns reporting sick pay.** If this option is chosen, Insurer will provide Employer by January 15th of each year with the information required by Federal law for Employer to prepare W-2s for its employees and file Federal and State information returns.

**B. Employer FICA Options with respect to Employer's share of Social Security and Medicare taxes:**

**FICA Match Option** can be selected as of your policy effective date for new groups. If you are an existing group, FICA Match Option can only be selected as of January 1st of the future tax year.

☐ **STANDARD. Employer retains responsibility for paying the Employer's share of Social Security and Medicare taxes.**Insurer will provide Employer with reports containing these amounts on a quarterly basis.

☐ **OPTION 1. Insurer pays the Employer's share of Social Security and Medicare taxes and deposits the taxes using the Insurer's EIN.** Employer will not be required to reimburse the Insurer for these amounts. Employer understands that the Employer FICA Match service will result in an increase of premium. If this Option is selected, the Insurer must prepare W-2 statements. Employer must select Option 1 in Section A.

**C. General Sick Pay Reporting Requirements**

Employer is responsible for providing Insurer with accurate information, including total wages paid employee during the calendar year, the last date the employee worked, and the employee contribution percentage of sick pay premium and whether these contributions were paid with BEFORE or AFTER tax dollars.

Insurer will notify Employer of the payments on which employee taxes were withheld. A weekly report will be sent to the Employer within the time required for Insurer's deposit of these amounts. Quarterly and Annual reports will also be sent to the Employer. Insurer will withhold and make timely deposits of employee Social Security and Medicare taxes.

Under no circumstances does Insurer assume any responsibility for Employer's portion of FUTA taxes or any other payroll or employment related tax, fee, premium or the like, including State disability insurance, State or local occupational tax or any Workers' Compensation tax which may be applicable to the sick pay.

Insurer agrees to withhold and deposit Federal income tax as required by the IRS or as requested by the employee on Federal W-4S form.

This Agreement will continue until replaced by a new Agreement, the Policy terminates and/or sick pay payments are discontinued. This Agreement replaces any prior dated Agreements.

**EMPLOYER**

Print Name: _____ Signature: _____

Title: _____ Date: _____

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# Group Transmittal

To be submitted with the Group Application

Policyholder _____ Group Number _____

## 1. Contact Information

Phone Number _____ Fax Number _____

Group Administrator (Plan changes, etc.) _____ Email Address _____

Administrative Contact (Daily Administration) _____ Email Address _____

Billing Contact (Billing Issues) _____ Email Address _____

Billing Address _____

City _____ State _____ Zip _____

## 2. Benefits & Eligibility - As indicated in your proposal.

**Minimum Hours** _____ (standard is 30 hours per week)

**Dependent Life** Policyholder will contribute: ❑ 0%; or ❑ Other _____%

**Waiting Periods**
*Subject to the actively at work provision contained in your proposal*

Current Employees: _____ ❑ Days ❑ Months ❑ Years

New Employees: _____ ❑ Days ❑ Months ❑ Years

Does any class have a different waiting period? ❑ Yes ❑ No

If YES, Please describe: _____

Does the waiting period apply to all coverages? ❑ Yes ❑ No

If NO, Please describe: _____

Employees are effective*:

- ❑ 1st day of employment (No waiting period)
- ❑ 1st day of the insurance month following completion of the eligibility waiting period
- ❑ The day following completion of the eligibiliy waiting period
- ❑ Other _____

*If medical underwriting is required, an individual's coverage will not take effect until the date the application is approved by Dearborn National. The effective date will be delayed for an employee who is not actively at work or a dependent whose activities are limited due to sickness or injury on the date coverage would otherwise take effect.*

**Definition of Earnings**

- ❑ As stated in the proposal
- ❑ Other* _____

**If "other" is selected, underwriting approval is required and the proposed rates are subject to change.*

**Annual Enrollment**

- ❑ Life / Life with Critical Illness / Disability — From ____/____ To ____/____ (ie: 9/1 to 9/30)
- ❑ Dental — From ____/____ To ____/____ (ie: 9/1 to 9/30)
- ❑ Not applicable

**Prior Credit For Rehires**

- ❑ Life / Life with Critical Illness / Disability — Is there prior employment credit for rehired employees? ❑ Yes ❑ No
  If YES, credit will be given for employees rehired within **6 months**, unless otherwise approved by The Company.
- ❑ Dental — Is there prior employment credit for rehired employees? ❑ Yes ❑ No
  If YES, credit will be given for employees rehired within **12 months**, unless otherwise approved by The Company.

**Other** Do you have any Canadian Employees that work in the United States? ❑ Yes ❑ No

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# Group Transmittal

To be submitted with the Group Application

Policyholder _____ Group Number _____

## 3. Group Administration

**Certificates** Email policy documents and certificates to:

❑ Group Administrator ❑ Administrative Contact ❑ Billing Contact

❑ Other _____ ❑ Other _____

❑ Other _____ ❑ Other _____

**Disability Coverage** If the employee pays all or a portion of the premium, how is it paid? ❑ Pre -Tax ❑ Post -Tax ❑ Not applicable

**Form 5500,Schedule A** Does this group have 100 or more eligible employees? ❑ Yes ❑ No

If YES, what is the benefit plan day, month, and year? ____/____/____

Information will be sent to the Group Administrator as listed in Section 1 above, unless otherwise stated below.

## 4. Billing

**Billing Options**
*For groups with 2-499 lives*

❑ List Billed
We will provide a monthly bill with each employee's cost itemized.

❑ Self-Administered, Paper
You provide to us the number of lives, volume, and premium, on a monthly basis.

❑ Self-Administered, Web (25+ Lives)
We provide initial enrollment details through our web based application and you maintain enrollment by managing additions, changes and terminations.

**Billing Method**
*For groups with 500+ lives*

❑ Self-Administered, Paper: You provide to us the number of lives, volume, and premium, on a monthly basis.

**TPA** ❑ Third Party Administrator. Please provide name: _____

**Billing Set Up**
*For List Billing Only*

❑ Alphabetically
You will receive **one bill**, with one total. Employees will be listed alphabetically.

❑ By Account*
You receive **multiple bills.** Employees are separated by accounts. You can pay with multiple checks.

❑ By Location*
You receive **one bill,** with subtotals and a grand total. Employees are separated by locations.

*Please indicate billing divisions on the enrollment census. Also include additional billing addresses in the special requests section of this form.

**Billing Frequency** ❑ Monthly ❑ Quarterly

Premium is payable on the first of the month unless mutually agreed upon otherwise and explained in the special requests section of this form.

## 5. Special Requests - Attach additional pages if needed.

Policyholder _____ Group Number _____

## *6. ERISA (SPD)*

Is this plan covered by ERISA?* ❑ Yes ❑ No

If this plan is an "employee welfare plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), it is subject to certain requirements including those relating to reporting and disclosure and fiduciary responsibility.

You, as the plan Administrator or authorized representative, have selected Fort Dearborn Life Insurance Company ("FDL") as the claims administrator of your plan, and you consent to the delegation of such authority to FDL. You acknowledge that, in some instances, FDL may delegate some or all of this authority to a third party administrator serving as the claims administrator and you consent to the delegation of such authority to a third party administrator.

FDL is not responsible for the compliance of your plan with respect to any legal or tax matters, and it cannot offer any legal or tax advice. You are responsible for compliance with all applicable laws, including benefits, employment, and tax laws, relating to the sponsorship and administration of your plan. You are also responsible for obtaining any necessary advice from your own legal and/or tax advisor regarding your plan.

FDL's obligations to you are governed solely by the terms of the applicable policy provisions, except as otherwise required by law.

**If you are not certain whether your plan is governed by ERISA, please visit the Department of Labor website for more information at: http://www.dol.gov/dol/topic/health-plans/erisa.htm*

## *7. Signature - This section must be signed.*

***Please ensure this form is complete and accurate. The information provided above, sold proposal and Application for Group Insurance will be used to create your groups Policy(ies) and Certificate(s).***

Group Administrator's Signature (Or other employee authorized to make plan changes) _____ Date _____

Typed or Printed Name _____