FORT DEARBORN LIFE
Insurance Company®
Chicago, Illinois

Enrollment Form

Return Completed Form to:
CoreSource
5200 Upper Metro Place #300
Dublin, OH 43017
Toll-free#: (800) 282-3920
Fax#: (614) 336-8428

☐ New Enrollment ☐ Change

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 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)			COVERAGE EFFECTIVE DATE
Basic Life/AD&D ☐ YES ☐ NO	**Dependent Life** ☐ YES ☐ NO	**Other** _____ ☐ Yes ☐ No $ _____	

VOLUNTARY COVERAGE(S) (Evidence of Insurability may be required on employee and spouse Life and Critical Illness Insurance)		**(A)dd (C)hange (D)elete**	**Total Amount of Coverage Applied for**	**If (C), my prior coverage was**
Optional Term Life: Employee	☐ YES ☐ NO			
Optional Term Life: Spouse	☐ YES ☐ NO			
Optional Term Life: Dependent Child(ren)	☐ YES ☐ NO			
Optional AD&D: ☐ **Individual** ☐ **Family**	☐ 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.

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 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. (Not enforceable in OR or VA.)

FOR FDL USE ONLY

EMPLOYEE SIGNATURE _____ DATE ____/____/____