Dearborn National™

☐ New Enrollment ☐ Change **Enrollment Form**

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

**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)** | | | | **Supplemental Life** ☐ Add ☐ Change ☐ Del. $ _____ | **Supplemental AD&D** ☐ Add ☐ Change ☐ Del. $ _____ | **Other** _____ ☐ Yes ☐ No $ _____ |
|---|---|---|---|---|---|---|
| **Basic Life/AD&D** ☐ YES ☐ NO | **STD Benefit** ☐ YES ☐ NO | **LTD Benefit** ☐ YES ☐ NO | **Dependent Life** ☐ 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** |
|---|---|---|---|---|
| **Voluntary Term Life: Employee** | ☐ YES ☐ NO | | | |
| **Voluntary Term Life: Spouse** | ☐ YES ☐ NO | | | |
| **Voluntary Term Life: Dependent Child(ren)** | ☐ YES ☐ NO | | | |
| **Voluntary AD&D:** ☐ **Individual** ☐ **Family** | ☐ NO | | | |
| **Voluntary Short-Term Disability - Incremental** | ☐ YES ☐ NO | | | |
| **Voluntary Short-Term Disability - % of Earnings** | ☐ YES ☐ NO | | | |
| **Voluntary Long-Term Disability - Incremental** | ☐ YES ☐ NO | | | |
| **Voluntary Long-Term Disability - % of Earnings** | ☐ YES ☐ 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.
- 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 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 ____/____/____