

EMPLOYEE APPLICATION TO FORT DEARBORN LIFE INSURANCE COMPANY

NAME OF EMPLOYEE (LAST)		(FIRST)		(MIDDLE)		GROUP NO.	SECTION NO.	CERT. NO.
ADDRESS OF EMPLOYEE (STREET NO.)				(CITY)		(STATE)		(ZIP CODE)
NAME OF EMPLOYER					SUBSIDIARY, AFFILIATE OR MEMBER OF			
DEPT.	DATE OF BIRTH (MO) (DAY) (YR)		DATE EMPLOYED (MO) (DAY) (YR)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BASIC SALARY FROM EMPLOYER \$	<input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> HOURLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> WEEKLY <input type="checkbox"/> ANNUALLY	
JOB TITLE - IF AMOUNT OF INSURANCE IS BASED ON TITLE, BE SURE THAT TITLE GIVEN AGREES WITH POLICY			SOCIAL SECURITY NO.			NO. OF HOURS WORKED IN NORMAL WEEK		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED
BENEFICIARY'S LAST NAME			FIRST NAME			INITIAL	RELATIONSHIP	AGE

IF MORE THAN ONE BENEFICIARY IS DESIGNATED, INTEREST WILL BE EQUAL UNLESS OTHERWISE INDICATED.

CLASS	OPTIONAL COVERAGE ENROLLED FOR (IF APPLICABLE)		
	DEPENDENT LIFE <input type="checkbox"/> YES <input type="checkbox"/> NO	OPTIONAL LIFE INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES AMOUNT \$ _____	LTD <input type="checkbox"/> YES <input type="checkbox"/> NO

I hereby apply for group insurance as indicated above and authorize my employer to make the necessary deductions, from my earnings to apply toward the premiums, if required. I understand that all insurance coverages will become effective according to the terms of the contract.

DATE _____ SIGNATURE _____

DO NOT COMPLETE SHADED AREAS.
 WITH BALL POINT PEN OR TYPED. IF BALL POINT PEN IS USED PRESS FIRMLY.