FORT DEARBORN LIFE
Insurance Company

Voluntary Term Life

Insurance Plan

Employee Coverage	Employee Premiums	Employee Coverage	Employee Premiums
$ 20,000	$ 3.60 per month	$ 70,000	$ 12.60 per month
$ 30,000	$ 5.40 per month	$ 80,000	$ 14.40 per month
$ 40,000	$ 7.20 per month	$ 90,000	$ 16.20 per month
$ 50,000	$ 9.00 per month	$100,000	$ 18.00 per month
$ 60,000	$ 10.80 per month		

Employee coverage cannot exceed 5 times your annual salary.

Spouse/Dependent[2]
$ 10,000 $ 3.16 per month

If Dependent Term Life Policy is elected, one premium covers all eligible dependents.

Who is Eligible?
Any active, full-time employee who works 20 or more hours per week is eligible for this group life insurance plan. There are no medical questions to answer.

How do you Enroll?
To enroll in your company's group life insurance plan, complete and sign the application and payroll deduction forms. Be sure to return them to your plan administrator.

How are Payments Made?
Premiums for this group term life insurance plan are paid through payroll deduction.

If my spouse and I both work, can we have coverage as an employee and a spouse?
No. You cannot be covered both as an employee and spouse. You should each buy coverage as an employee.

What happens if I become totally disabled?
If you become disabled before age 60 and remain so for six consecutive months, you can keep your coverage in force to age 65 without paying premiums for as long as your total disability continues and you provide proof of disability as required. If you become disabled after age 60, coverage continues for up to 12 months, provided premiums are paid when due.

What if I am not actively at work on the date coverage is to begin?
Your coverage will begin when you resume active, full-time work.

Will dependent coverage start on the date of issue?
Yes, unless your spouse or dependent children are hospital-confined. Coverage for these dependents will be delayed until they are no longer hospital-confined.

If I am diagnosed with a terminal illness, will I receive any portion of my benefit before I die?
In most states, you may collect 50% of your death benefit (up to $50,000) if your life expectancy is 12 months or fewer[1]. For completed details, please refer to your certificate of insurance.

When are benefits not payable?
Life insurance benefits, including Waiver of Premium, will not be available for a loss caused by suicide or attempted suicide within one year from the effective date of the voluntary life benefit.

Plan Options:
Eligible employees can purchase up to five times their annual salary in $10,000 increments. The minimum coverage is $20,000 with a maximum of $300,000 with guarantee issue up to $100,000[2]. Amounts above the guarantee issue limit of $100,000 will be subject to satisfactory evidence of insurability. Your coverage will be reduced by 50% at age 70.

Spouse & Dependent Coverage:
Employees can purchase $10,000 in life insurance for spouses and eligible dependent children without medical questions. Your spouse can apply for additional insurance in increments of $5,000 not to exceed 50% of the amount the employee applies for[3]. All amounts in excess of $10,000 will be subject to satisfactory evidence of insurability[2]. Your spouse's coverage will terminate when he/she attains the age of 70.

Converting Coverage:
If your coverage ends, you and your insured spouse (under age 70) and your eligible children (under the limiting age) may, within 31 days, elect to convert your group term insurance to an individual whole life policy without evidence of insurability by paying an annual premium to the company. This option is not available if coverage ends because of non-payment of premium or if the employer moves the plan to another carrier.

Since 1969, Fort Dearborn Life Insurance Company has provided valuable group benefits insurance protection to meet the recruiting needs of employers and the family security needs of employees.

Fort Dearborn Life Insurance Company is rated A+ (Superior) by A.M. Best Company[4].

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[1] *The percentage of death benefits may vary by state law.*
[2] *Evidence of insurability required if insurance is applied for after the date of eligibility.*
[3] *Amount of dependent life coverage available may vary by state.*
[4] *A.M. Best Company rates the overall financial condition of a company using a scale of A++ (Superior) to F (In Liquidation).*

FORT DEARBORN LIFE
Insurance Company®

Enrollment Application

Return To: Plan Administration, Ltd.
580 Hazard Avenue
Enfield, CT 06082

Please print or type all information. Complete and sign at the bottom.

EMPLOYEE Name — LAST	FIRST	MIDDLE INITIAL	Social Security No.	Group Number	Division	Class

Home Address - City	State	Zip	Sex	Date of birth	Marital status
			M ❑ F ❑		

Your Occupation	Employer name	Hire date	Hours worked per week	Annual salary

Primary benficiary (For Employee Life)	Social Security #	Relationship	Date of Birth

Contingent Beneficiary	Social Security #	Relationship	Date of Birth

Life Coverage Requested:

❑ **Check Employee Coverage desired**

Coverage Amount	Monthly Rates
❑ $ 20,000	$3.60
❑ $ 30,000	$5.40
❑ $ 40,000	$7.20
❑ $ 50,000	$9.00
❑ $ 60,000	$10.80
❑ $ 70,000	$12.60
❑ $ 80,000	$14.40
❑ $ 90,000	$16.20
❑ $100,000	$18.00
❑ $_____	

❑ **Spouse/Dependent Coverage**

$10,000/$10,000 $3.16

If applying for Spouse/Dependent Coverage, complete section below:

	Name (Last, First, MI)	Social Security #	Date of Birth	Sex (M/F)
Spouse				
Child(ren)				

If dependent children are full-time students in college, vocational or trade school, please complete the following:

Child(ren)	Name of School	# of Hours

To decline coverage, complete this section. ❑ **Employee** ❑ **Spouse/Dependent**

I understand that I have been given an opportunity to participate in the group insurance plan offered by my employer. I am refusing the term life insurance coverage indicated above for which I am required to contribute. If I and/or my dependents wish to participate at a later date, I understand that coverage(s) may be limited and satisfactory evidence of insurability may be required.

Reason for refusing coverage: _____

Employee's signature: _____ Date: _____

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.

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 may subject such person to criminal and civil penalties.

Employee's signature: _____ Date: _____

PAL Plan Administration, Ltd.

Administered by
Plan Administration Ltd.
580 Hazard Ave • Enfield, CT 06082
860-272-1135

Products are underwritten by
FORT DEARBORN LIFE
Insurance Company®