Dearborn National™

Beneficiary Form

Administrative Offices: Downers Grove, Illinois I Dallas, Texas

❑ New ❑ Change **PLEASE TYPE OR PRINT WITH BALLPOINT PEN.**

NAME OF EMPLOYEE — LAST	FIRST	MIDDLE INITIAL	SEX	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
			M ❑ F ❑	MO / DAY / YEAR	MO / DAY / YEAR

SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)

EMPLOYER	GROUP NO.	AGENCY

Irrevocable Beneficiary: ❑ Yes ❑ No **Note:** If you select irrevocable beneficiary, you may not change the beneficiary without the consent of the irrevocable beneficiary. An irrevocable beneficiary has a vested interest in the proceeds of the contract, therefore the contract holder cannot exercise certain rights without the permission of the irrevocable beneficiary.

BENEFICIARY Must Be Completed

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%. SEE BELOW FOR DETAILS.

	First Name	Last Name	Date of Birth	Social Security Number	Relationship	Benefit %
Primary			MO / DAY / YEAR			%
Primary			MO / DAY / YEAR			%
Contingent			MO / DAY / YEAR			%
Contingent			MO / DAY / YEAR			%

WARNING: 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 Oregon or Virginia.)

SIGNATURE OF EMPLOYEE OR MEMBER _____

DATE SIGNED ____/____/____ MO DAY YEAR

FOR FDL USE ONLY
Effective Date
/ /

Important Note For Married Employees: If you live in a community property state, you should obtain the signature of your spouse if your spouse wil not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NM, NV, TX, WA and WI. Payment of benefits may be delayed or disputed unless your spouse consents to waive his or her rights to any community property interest in the benefits. We have provided below a "Spousal Consent for Community Property States" for your spouse's signature. **FORT DEARBORN WILL NOT BE LIABLE FOR DAMAGES DUE TO ANY DELAY OR DISPUTE IN PAYMENT OF BENEFITS IF YOU CHOOSE NOT TO OBTAIN YOUR SPOUSE'S SIGNATURE.**

Spousal Consent for Community Property States: I hereby consent to the Primary Beneficiary designated by my spouse. This consent supersedes any prior spousal consent I may have given under this plan.

Spouse Signature _____ Date _____ ❑ Employee has no legal spouse

Primary Beneficiary: The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary. ***If you specify benefit percentages, the total must equal 100%.***
If you do not specify benefit percentages, proceeds will be paid in equal shares to the primary beneficiaries who survive you.

Contingent Beneficiary: The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. ***If you specify benefit percentages, the total must equal 100%.***

No Beneficiary: If you do not name a beneficiary, or if no beneficiary survives you, we will pay death benefits in the order of survivorship shown in your group certificate.

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☐ 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**	**Supplemental AD&D**	**Other** _____
Basic Life/AD&D	**STD Benefit**	**LTD Benefit**	**Dependent Life**	☐ Add ☐ Change ☐ Del.	☐ Add ☐ Change ☐ Del.	☐ Yes ☐ No
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	$ _____	$ _____	$ _____

VOLUNTARY COVERAGE(S) (Evidence of Insurability may be required on employee & spouse/registered domestic partner Life 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/Registered Domestic Partner	☐ YES ☐ NO			
Voluntary Term Life: Dependent Child(ren)	☐ YES ☐ NO			
Voluntary AD&D: ☐ **Individual** ☐ **Family**	☐ NO			
Voluntary Short-Term Disability	☐ YES ☐ NO			
Voluntary Long-Term Disability - Incremental	☐ YES ☐ NO			
Voluntary Long-Term Disability - % of Salary	☐ YES ☐ NO			

SPOUSE/REGISTERED DOMESTIC PARTNER NAME (IF APPLICANT) LAST FIRST M.I.	SEX M ☐ F ☐	SPOUSE/REGISTERED DOMESTIC PARTNER DATE OF BIRTH	SPOUSE/REGISTERED DOMESTIC PARTNER 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.
- Your weekly STD benefit may not exceed 60% of your basic weekly earnings (excluding bonuses, overtime and any extra compensation other than commissions).
- 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 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 materials thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

FOR FDL USE ONLY

EMPLOYEE SIGNATURE _____ DATE ____/____/____

Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands and Guam.