

Group No./Div. _____

2007 V1

EMPLOYEE APPLICATION To be completed by each applicant

EMPLOYEE INFORMATION					
<u>NAME OF EMPLOYEE</u>	<u>FIRST</u>	<u>MIDDLE</u>	<u>LAST</u>	<u>DATE OF HIRE (FULL TIME) MO / DAY / YEAR</u>	<u>HRS WORKED / WEEK</u>
<u>SOCIAL SECURITY NO.</u>	<u>SEX</u>	<u>DATE OF BIRTH</u> MO / DAY / YEAR		<u>ANNUAL SALARY</u>	<u>JOB TITLE</u>
	<input type="checkbox"/> M <input type="checkbox"/> F			\$	
<u>EMPLOYER</u>		<u>STREET</u>		<u>CITY</u>	<u>ZIP CODE</u>
BENEFIT SELECTION					

Benefit : Eligible employees select weekly benefit, subject to 70% of basic weekly income

Initial Enrollment Decline Coverage Open Enrollment: Change (Benefit Amount: _____)

Indicate choice of plan:

Select Plan:	Providing a Weekly Benefit of:	Your Annual Salary Must be at Least:	Select Plan:	Providing a Weekly Benefit of:	Your Annual Salary Must be at Least:
<input type="checkbox"/>	\$300	\$22,285	<input type="checkbox"/>	\$550	\$40,875
<input type="checkbox"/>	\$350	\$26,000	<input type="checkbox"/>	\$600	\$44,571
<input type="checkbox"/>	\$400	\$29,715	<input type="checkbox"/>	\$650	\$48,286
<input type="checkbox"/>	\$450	\$33,430	<input type="checkbox"/>	\$700	\$52,000
<input type="checkbox"/>	\$500	\$37,143	<input type="checkbox"/>	\$750	\$55,714

Benefits Payable: (15th Day Accident; 15th Day Sickness)

- New STD plans and subsequent increases in the weekly benefit amount are subject to a 12/12 pre-existing condition exclusion.
- Benefits are payable for non-occupational disabilities only.
- This coverage does not replace or change any requirement for coverage under any Worker's Compensation or similar law.

GENERAL CONDITIONS

1. All active employees who work at least 20 hours a week are eligible to enroll.
2. Each employee must make written application to Fort Dearborn Life Insurance Co. and must be Actively at Work on his effective date for coverage to become effective. If not Actively at work (as defined in the policy) on the day coverage would otherwise become effective, an employee's coverage will begin on the date of his return to Active Work.
3. I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits.
4. If I have declined coverage, I understand that if I choose to enroll at a later date, my cost may be higher.

Date Signed _____ Employee Signature _____

THIS FORM MAY BE DUPLICATED