BlueCross BlueShield of Illinois

Dearborn National*
Underwritten by Fort Dearborn Life Insurance Company*

APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

① ENROLLEE: **New Enrollment:** ☐ Timely ☐ Special ☐ Late | **Open Enrollment:** ☐ New Member ☐ Plan Change ☐ Add Dependents

② EFFECTIVE DATE: ___/___/___ | **Group Number:** | **Section Number:** | **Identification Number:**

③ COBRA / Illinois Continuation Section | **Employee Status:** ☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date___/___/___

☐ **COBRA:** Start Date ___/___/___ Projected End Date ___/___/___ | ☐ **IL Continuation Privilege:** Start Date ___/___/___ Projected End Date ___/___/___

Previously covered with group as:

☐ 1. Employee (termination of employment, reduction in hours, other.) ☐ 3. Dependent (reach age limit, other.)

☐ 2. Spouse (divorce from employee, death of employee, other.) ☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ COVERAGE APPLIED FOR: Check all that apply.**

Medical

☐ Traditional	☐ PPO	☐ BlueDecision PPO
☐ HMO Illinois	☐ BlueEdge HCA	☐ PPO Value Choice
☐ w/HCA (BlueEdge HMO)	☐ BlueChoice Select	☐ CPO
☐ BlueAdvantage HMO	☐ BlueEdge Select HSA	☐ CPO Value Choice
☐ w/HCA (BlueEdge HMO)	☐ BlueEdge Select HCA	☐ Vision
☐ BlueEdge HSA	☐ BlueEdge Direct HCA	☐ Hearing
	☐ BlueEdge Select Direct HCA	☐ Medicare Supplement

Dental

☐ Individual / Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Enter Dental Group number if different than Medical Group policy number.

☐ Dental Group #: _____

☐ BlueCare Dental PPO

☐ BlueCare Dental HMO (Select your dental office in section 6 and 7 when applicable)

Dearborn National Group #: _____

Previous BC (Illinois) or HMO Membership:

Group #: _____ Section #: _____

Identification #: _____

⑤ CHANGES TO EXISTING MEMBERSHIP: Check all that apply.

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

CHANGES

Date: ___/___/___

- ☐ HMO Medical Group/IPA
- ☐ PCP and/or WPHCP
- ☐ Name
- ☐ Address
- ☐ Telephone
- ☐ Reinstate
- ☐ From PPO to HMO
- ☐ From HMO to PPO
- ☐ From HMOI to BA HMO
- ☐ From BA HMO to HMOI
- ☐ Medicare Coverage
- ☐ FDL Beneficiary

ADD DEPENDENTS

Date: ___/___/___

- ☐ Marriage
- ☐ Newborn
- ☐ Adoption/Placement
- ☐ Legal Guardianship
- ☐ Other: _____

CANCEL DEPENDENTS

Date: ___/___/___

- ☐ Divorce
- ☐ Age Limit
- ☐ Other: _____

NOTE:
Only list dependents to be added or dropped in the Family Coverage Information Section ⑦.

CANCEL
(Check all that apply)

Date: ___/___/___

- ☐ Terminate Coverage
- ☐ Waive Coverage**
- ☐ Leave/Layoff
- ☐ Out of Service Area Move
- ☐ Other: _____

***After checking the appropriate physician change, circle reason:**

☐ PCP ☐ WPHCP

A. Availability **B. PCP moved office**
C. Location **D. PCP added to Network**
E. Dissatisfied with PCP **F. PCP office/facility undesirable**
G. Staff **H. Other** _____

****If not electing coverage, please read, complete and sign Section ⑪.**

⑥ EMPLOYEE INFORMATION:

Company Name:

Last Name:	First Name:	Mid. Initial	E-Mail Address:	Cell Phone Number

Street Address:	Apt. No.:	City:	State:	Zip:

Date of Birth: ___/___/___ Are You Eligible for Family Coverage: ☐ No ☐ Yes Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security Number: ___ — ___ — ___ Employee Identification Number (if known): _____

Telephone No.: Bus.: ( ) _____ Home: ( ) _____ Date of Hire: ___/___/___

Dept. No.: _____ Payroll Location: _____ Employee Clock No.: _____

If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____

PCP #: _____ PCP Name: _____ WPHCP Medical Group/IPA#: _____

WPHCP Medical Group Name: _____ WPHCP (Physician) #: _____ WPHCP (Physician) Name: _____

If CPO/CPO Value Choice: Network # CO: _____ **If BlueCare Dental HMO: Office ID#:** _____

Employment Status: ☐ **Actively at Work** ☐ **Retired** **If retired, retirement date:** _____ ☐ **COBRA/IL Continuation**

A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

Are you covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes** **If Yes, the section below must be completed:**

HIC #:	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦ Ⓐ SPOUSE/DOMESTIC PARTNER: Date of Birth: ___/___/___ **Last Name** (Only If Different): _____

First Name: _____ Social Security Number: ___ — ___ — ___

If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____ WPHCP Medical Group/IPA #: _____

PCP #: _____ PCP Name: _____ WPHCP Medical Group Name: _____

WPHCP (Physician) #: _____ WPHCP (Physician) Name: _____ **If BlueCare Dental HMO: Office ID#:** _____

A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes** **If Yes, the section below must be completed:**

HIC #:	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

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* 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, Guam and Puerto Rico.

EMPLOYEE AND DEPENDENT INFORMATION: Company Name: Group #:

Employee Last Name: Employee First Name: Mid. Initial

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦ Ⓑ ☐ SON ☐ DAUGHTER Date of Birth: ___/___/___ Last Name (Only If Different): First Name:
Address (if different from Employee's address): Social Security Number: ___-___-___ If HMO: Medical Group/IPA #:
Medical Group/IPA Name: PCP #: PCP Name: WPHCP Medical Group/IPA #:
WPHCP Medical Group Name: WPHCP (Physician) #: WPHCP (Physician) Name*:
If BlueCare Dental HMO: Office ID#:
Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, the section below must be completed:**
HIC #: MEDICARE B: ESRD DIALYSIS: DISABILITY:
MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___
Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

☐ SON ☐ DAUGHTER Date of Birth: ___/___/___ Last Name (Only If Different): First Name: ☐ ELIGIBLE MILITARY PERSONNEL
Address (if different from Employee's address): Social Security Number: ___-___-___ If HMO: Medical Group/IPA #:
Medical Group/IPA Name: PCP #: PCP Name: WPHCP Medical Group/IPA #:
WPHCP Medical Group Name: WPHCP (Physician) #: WPHCP (Physician) Name*:
If BlueCare Dental HMO: Office ID#:
Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, the section below must be completed:**
HIC #: MEDICARE B: ESRD DIALYSIS: DISABILITY:
MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___
Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

☐ SON ☐ DAUGHTER Date of Birth: ___/___/___ Last Name (Only If Different): First Name: ☐ ELIGIBLE MILITARY PERSONNEL
Address (if different from Employee's address): Social Security Number: ___-___-___ If HMO: Medical Group/IPA #:
Medical Group/IPA Name: PCP #: PCP Name: WPHCP Medical Group/IPA #:
WPHCP Medical Group Name: WPHCP (Physician) #: WPHCP (Physician) Name*:
If BlueCare Dental HMO: Office ID#:
Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, the section below must be completed:**
HIC #: MEDICARE B: ESRD DIALYSIS: DISABILITY:
MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___
Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

⑧ OTHER INSURANCE INFORMATION:

If you or any of your family members have OTHER GROUP COVERAGE, **Check all that apply.** ☐ Health: Policy #: ☐ Dental: Policy #:
☐ Prescription Drug Coverage: Policy #: ☐ Vision: Policy #: ☐ Hearing: Policy #:
If Yes: Is the other insurance: ☐ Single Coverage ☐ Family Coverage
EMPLOYED BY: Insured's Name: Date of Birth: ___/___/___
Insurance Company Name: Address:
City: State: Zip: Telephone Number:

⑨ DEARBORN NATIONAL:

Employee Job Title: **Class Type:**
Basic Salary: $ ☐ Hourly ☐ Weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually
Check Coverage Applied For: Term Life/AD&D: ☐ No ☐ Yes $ Dependent Life: ☐ No ☐ Yes $ Weekly Income: ☐ No ☐ Yes $
Supplemental Life: ☐ No ☐ Yes $ Long Term Disability: ☐ No ☐ Yes $ ☐ Voluntary AD&D: $ ☐ Single ☐ Family
Permanent Life Insurance: ☐ No ☐ Yes $ **If Yes:** ☐ Automatic Premium Loan or ☐ Replaces An Existing Policy
BENEFICIARY: Note: If more than one Beneficiary, interest will be equal unless otherwise indicated.
Last Name: First Name: Relationship:

⑩ **I APPLY FOR COVERAGE AS INDICATED ABOVE,** for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical, dental coverage and health maintenance coverage), and/or Dearborn National (providing the life and disability insurance) (the Company). I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Date Signed: ___/___/___ **Signature of Applicant:**

⑪ If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Not enrolling for: ☐ Myself ☐ My spouse ☐ My spouse and dependents ☐ My dependents ☐ Myself, my spouse and my dependents

Reason: ☐ Covered under spouse's employer-based health insurance plan (complete "Other Insurance Information" in ⑧) ☐ Covered under a Medicare supplement plan
☐ Other (please explain)

Date Signed: ___/___/___ **Signature of Applicant:**

*A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

aetna® Dental Enrollment/Change Request

Aetna Life Insurance Company*

Instructions: *Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.*

Employer group information – To be completed by employer.	Control	Suffix	Account	Plan number
	0876576	10		

Employer name – full name of business or organization
City of Berwyn, Illinois

Employer address (street, city, state, ZIP code) – primary location of business or organization
6700 W 26th Street, Berwyn, IL 60402

A. Type of activity – Employee completes sections A – E. *Please print clearly.*

Enrollment – *Check one.*
- ☐ New enrollee / subscriber

Effective date: ____/____/____

Date of hire: ____/____/____

- ☐ Rehire / reinstatement

Date of rehire / reinstatement ____/____/____

Change – *Check all that apply.*
- ☐ Add spouse
- ☐ Add dependent child
- ☐ Name change
- ☐ Other _____
- ☐ Control / Suffix / Acct / Plan _____

Date of event: _____

Reason: _____

Remove or terminate – *Check all that apply.*
- ☐ Remove spouse
- ☐ Remove dependent child
- ☐ Employee withdrawal / termination
- ☐ Cancel coverage

Effective date: _____

Reason: _____

Continuation of coverage, i.e., COBRA, state
Not all options are available. Contact employer for available options.

Coverage for: ☐ Employee ☐ Dependents

Length of continuation (months):
- ☐ 18 ☐ 36 ☐ Other ____
- ☐ 29 – Attach disability determination from the Social Security Administration

Date of loss of coverage: _____

Date of qualifying event: _____

Continuation of coverage expiration date: _____

B. Employee information

Social Security number	Last name, first name, middle initial		Home telephone ( ) -	Work telephone ( ) -

Employee status	Employee home address	Apt. number	City, state	ZIP code
☐ Active ☐ Retired				

C. Plan options – *Check one.* Your selection must be offered by your employer.

☐ Indemnity Dental	☐ Dental EPP	☐ FOC / Indemnity
☐ DentalFund / HealthFund	☐ DMO® / Advantage / Basic	☐ FOC / PPO
☐ Dental PPO		☐ FOC / DMO®

D. Individuals covered – *List individuals for whom you are enrolling or adding / changing / removing coverage.*

☐ **Check this box if you are refusing coverage for your dependents.** **** Provide details for "Yes*" responses below.***

(A)dd (C)hange (R)emove	1. Employee name - Last name, first name, middle initial	Relation code	Sex (M/F)	Birthdate (MM/DD/YYYY)
___		Self		

Social Security number	Late entrant	Prior insur. plan	Other dental coverage	Currently covered by Medicare	Handi-capped	Student	Primary dentist office ID number	Current patient
	Yes ☐	Yes* ☐	Yes* ☐	Yes* ☐	N/A	N/A		Yes ☐

(A)dd (C)hange (R)emove	2. Spouse name - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	Birthdate (MM/DD/YYYY)
___				

Social Security number (if dependent has no SSN, write "None")	Late entrant	Prior insur. plan	Other dental coverage	Currently covered by Medicare	Handi-capped	Student	Primary dentist office ID number	Current patient
	Yes ☐	Yes* ☐	Yes* ☐	Yes* ☐	Yes ☐	Yes ☐		Yes ☐

Continued on page 2

D. Individuals covered ***(Continued) – List individuals for whom you are enrolling or adding / changing / removing coverage.***

**** Provide details for "Yes*" responses below.*** Attach sheet to list additional children.

(A)dd (C)hange (R)emove	**3. Child name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)
___				

Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

(A)dd (C)hange (R)emove	**4. Child name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)
___				

Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

(A)dd (C)hange (R)emove	**5. Child name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)
___				

Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

(A)dd (C)hange (R)emove	**6. Child name** - Last name, first name, middle initial (Explain difference in last name in Special remarks.)	Relation code	Sex (M/F)	**Birthdate** (MM/DD/YYYY)
___				

Social Security number (if dependent has no SSN, write "None")	Late entrant **Yes** ☐	Prior insur. plan **Yes*** ☐	Other dental coverage **Yes*** ☐	Currently covered by Medicare **Yes*** ☐	Handi-capped **Yes** ☐	Student **Yes** ☐	Primary dentist office ID number	Current patient **Yes** ☐

1. If **yes** to **Prior insurance plan** and / or **Other medical coverage** above, provide effective dates, name and policy number of insurance carrier, HMO, or other source and your **member identification number**.

2. If **yes** to **Other dental coverage** and / or **Currently covered by Medicare** above, provide effective dates, name and policy number of insurance carrier, dental plan or other source and your **member identification number**.

3. Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If **yes**, who and what address?

Special remarks:

Race / ethnicity – optional This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.

Employee 1.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child** 4.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child** 5.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Child 3.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	**Child** 6.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

Conditions of enrollment

Applicant acknowledgments and agreements

On behalf of myself and the dependents listed, I agree to or with the following:

1. *I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna"):
   - Aetna DMO, Aetna Dental PPO, Dental EPP, Aetna HealthFund / Aetna DentalFund, and Aetna Indemnity Dental: Aetna Life Insurance Company
   - In the states of AZ, CA, GA, MD, MO, NC, NJ and TX, Aetna DMO, Advantage and Basic plans may also be provided by one of the following: Aetna Dental of California, Inc., Aetna Dental Inc. (NJ), Aetna Dental Inc. (TX), Aetna Health Inc., or Aetna Health Inc. (AZ).
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment / Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment / Change Request form, including those involving mental health, substance abuse and HIV / AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand I am entitled to a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers (including all participating primary care dentists) and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

E. Employee signature

☐ *By checking this box you agree to use our member self-service website for all future printed materials.*

I certify that all information supplied in this form is true and complete to the best of my knowledge and / or belief. I have read and agree to the Conditions of enrollment on this Employee Enrollment / Change Request form. I understand that in the event I fail to sign this form within 31 days after the above transaction request or that for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected.

Misrepresentation: 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 may have violated state law.

Attention Colorado residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Kentucky residents: 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.

Attention Tennessee residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee signature *- required*	***Date (Month/Day/Year)***	***Employee email address (optional)***	***Primary language spoken***
X			

Please make a copy for your records. **Visit us at www.aetna.com.**

Instructions

Employer – Complete the **Employer group information** at the top of page 1.

Employee – Complete sections A – E.

Section A – Type of activity:

- Check box(es) indicating reason(s) for submitting this Enrollment / Change Request.
- Provide Effective date(s) and Date of event(s) where requested.

Section B – Employee information:

- Complete **all** information in order for your Enrollment / Change Request to be processed.

Section C – Plan options: Select only an option offered by your employer.

Section D – Individuals covered:

- Add / Change / Remove – Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, and Social Security number for each individual.
- *Relationship code* – Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special remarks.**
- **Late entrant:** If you are **not** enrolling within your employer's eligible enrollment period, check **Yes**.
- If you or your dependent(s) were covered under your employer's or other **Prior insurance plan**, check the **Yes** box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, dental plan or other source and your **member identification number** for the insurance plan in the space provided in number 1.
- If you or your dependent(s) have **Other dental coverage** and / or are **Currently covered by Medicare**, check the **Yes** box(es) and provide beginning and ending effective dates, name and policy number of insurance carrier, dental plan or other source and your **member identification number** for the insurance plan in the space provided in number 2.
- If a dependent is handicapped and financially dependent, check **Yes** and provide proof of handicapped status from the attending physician.
- If a dependent is a student, check **Yes**. Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.
- Primary dentist office ID number: Locate the office ID number for the primary dentist from the appropriate provider directory or from the online provider directory at **www.aetna.com**.
- If you are a current patient, please check the **Yes** box under Current patient.
- Optional – Using the KEY provided, please enter the Race / ethnicity code for each individual. If your Race / ethnicity is "Other," print the Race / ethnicity for each individual in the space provided.

Section E. Employee signature:

- Complete this section for all new enrollments or coverage changes.
- Employee must sign and date the Enrollment / Change Request in order for it to be processed.
- By checking the box provided, you agree to use our member self-service website for all future printed materials.

VSP
Vision care for life

Enrollment Form with Dependent Data

Name of group (employer): City of Berwyn

Employee last name, first name, middle initial: _____

Social Security Number (Last 4 digits): _____

Employee Home Address: _____

Email Address: _____ Date of birth (month/date/year): _____

Gender: ☐ male ☐ female

Type of coverage selected: ☐ employee only ☐ employee and one dependent ☐ employee and child(ren) ☐ employee and family

Effective Date of Coverage: 05/01/2021 *** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /
			☐S ☐C ☐H ☐T	/ /

Employee Signature: _____

Please return this form to your benefits administrator. Do not return to VSP.

The City of Berwyn

Ricardo Macedo
Benefits Administrator

A Century of Progress with Pride

To Employee:

The carrier of the City of Berwyn Term Life Insurance Policy #F151642 is Dearborn National Insurance Company 1020 31st St. Downers Grove Il 60515

Your Policy is in the amount of $25,000

Please keep this letter available with your insurance papers so your family will have information to reach our office when needed to process in case of a death claim.

Sincerely,

Ricardo Macedo
Benefits Administrator
City of Berwyn
708-749-6467
rmacedo@ci.berwyn.il.us

BlueCross BlueShield of Illinois

BENEFICIARY DESIGNATION FORM

Return to Blue Cross and Blue Shield of Illinois at:
Attention: Claims Department
P.O. Box 7070
Downers Grove, IL 60515

INSTRUCTIONS (PLEASE PRINT, SIGN AND DATE THIS FORM IN BLACK INK)

Employee/Retired Employee Name	SSN	Date of Birth	Home Telephone Number

Home Address	City	State	Zip

Employer	Group Number

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.

DEFINITIONS & STATEMENTS

Primary Beneficiary means the person or persons who will receive the benefits in the event of the Insured's death. Proceeds will be divided in equal shares if multiple primary beneficiaries are named, unless otherwise indicated. If percentages are listed, the total of the combination must equal 100%.

Contingent Beneficiary means the person or persons who will receive the benefits if the primary beneficiary is not living at the time of the Insured's death.

Will or Trust as Beneficiary Designation can be done by using the following written statement: "*To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust].*" If you wish to designate a testamentary trust as beneficiary (i.e. created by will), you should recognize the possibility that your will which was intended to create a trust may not be admitted to probate (because it is lost, contested or suspended by a later will). Claim payment delays can result if the beneficiary designation does not provide for this situation. **

Minors as Beneficiary Designation can be done by using this document. However, please note if your beneficiary is a minor at the time of claim, payments may be delayed due to special issues raised by these designations. **

Dependent Beneficiary – In the event a dependent dies, the employee is the beneficiary of their life insurance proceeds.

**You may want to obtain the assistance of an attorney to help consider any special circumstances before drafting your beneficiary designation.

BENEFICIARY DESIGNATION FOR ALL EMPLOYEE/RETIRED EMPLOYEE LIFE BENEFITS

Primary Beneficiary	Birth Date	Relationship	Social Security #	Address	%
Contingent Beneficiary	**Birth Date**	**Relationship**	**Social Security #**	**Address**	**%**

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.)

Employee/Retired Employee Signature _____ **Date** _____

Important Note For Married Employees: If you live in a community property state/territory, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states/territories currently include: AZ, CA, GU, ID, LA, NM, NV, PR,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. **BLUE CROSS AND BLUE SHIELD OF ILLINOIS 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/Territories: 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

VOLUNTARY GROUP LIFE AND AD&D
PREMIUM RATE GRID

BlueCross BlueShield of Illinois

CITY OF BERWYN - #F151642

Eligibility

You are eligible to enroll if you work the minimum number of hours per week by your employer, and you have satisfied any waiting period.

You must be covered under the basic life plan sponsored by your employer in SD and VT.

Voluntary Life Insurance

Employee Benefit: **$10,000 - $500,000 in $10,000 increments.**

Spouse Benefit: **$5,000 - $250,000 in $5,000 increments, not to exceed 50% of the employee amount.**

Guarantee Issue Amounts for new hires within 31 days of eligibility

$100,000 for employees under age 60;
$20,000 for employees age 60-69;
$20,000 for spouses under age 70.

Child Coverage

Ages 15 days to 6 months: **$100**

Ages 6 months to 19 years (23 years if full time student): **$2,500- $10,000 in $2,500 increments.**

Voluntary AD&D Insurance

Benefits from $10,000 to $500,000 in $10,000 increments.
The Individual Plan covers you in the event of accidental death or dismemberment.
The Family Plan covers you, your spouse and your eligible dependent children.
The spouse benefit is equal to 50% of your benefit and the child benefit is 10% of your benefit.

Voluntary Life	
Monthly rates per $1,000	
Age	**Rates**
Under 30	$0.070
30-34	$0.080
35-39	$0.100
40-44	$0.150
45-49	$0.260
50-54	$0.490
55-59	$0.790
60-64	$0.960
65-69	$1.660
70-75	$3.910
75 and over	$9.630
Voluntary AD&D	
Monthly rates per $1,000	
Individual Plan	$0.050
Family Plan	$0.080
Dependent Life (Children)	
Monthly rates per Family	
$2,500	$0.50
$5,000	$1.00
$7,500	$1.50
$10,000	$2.00

Voluntary Life Insurance

Bi-Weekly Premium Cost (Based on 26 payroll deductions per year)

Benefit Amount	VAD&D Individual	VAD&D Family	ATTAINED AGE <30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.23	$0.37	$0.32	$0.37	$0.46	$0.69	$1.20	$2.26	$3.65	$4.43	$7.66	$18.05	$44.45
$20,000	$0.46	$0.74	$0.65	$0.74	$0.92	$1.38	$2.40	$4.52	$7.29	$8.86	$15.32	$36.09	$88.89
$30,000	$0.69	$1.11	$0.97	$1.11	$1.38	$2.08	$3.60	$6.78	$10.94	$13.29	$22.98	$54.14	$133.34
$40,000	$0.92	$1.48	$1.29	$1.48	$1.85	$2.77	$4.80	$9.05	$14.58	$17.72	$30.65	$72.18	$177.78
$50,000	$1.15	$1.85	$1.62	$1.85	$2.31	$3.46	$6.00	$11.31	$18.23	$22.15	$38.31	$90.23	$222.23
$60,000	$1.38	$2.22	$1.94	$2.22	$2.77	$4.15	$7.20	$13.57	$21.88	$26.58	$45.97	$108.28	$266.68
$70,000	$1.62	$2.58	$2.26	$2.58	$3.23	$4.85	$8.40	$15.83	$25.52	$31.02	$53.63	$126.32	$311.12
$80,000	$1.85	$2.95	$2.58	$2.95	$3.69	$5.54	$9.60	$18.09	$29.17	$35.45	$61.29	$144.37	$355.57
$90,000	$2.08	$3.32	$2.91	$3.32	$4.15	$6.23	$10.80	$20.35	$32.82	$39.88	$68.95	$162.42	$400.02
$100,000	$2.31	$3.69	$3.23	$3.69	$4.62	$6.92	$12.00	$22.62	$36.46	$44.31	$76.62	$180.46	$444.46
$110,000	$2.54	$4.06	$3.55	$4.06	$5.08	$7.62	$13.20	$24.88	$40.11	$48.74	$84.28	$198.51	$488.91
$120,000	$2.77	$4.43	$3.88	$4.43	$5.54	$8.31	$14.40	$27.14	$43.75	$53.17	$91.94	$216.55	$533.35
$130,000	$3.00	$4.80	$4.20	$4.80	$6.00	$9.00	$15.60	$29.40	$47.40	$57.60	$99.60	$234.60	$577.80
$140,000	$3.23	$5.17	$4.52	$5.17	$6.46	$9.69	$16.80	$31.66	$51.05	$62.03	$107.26	$252.65	$622.25
$150,000	$3.46	$5.54	$4.85	$5.54	$6.92	$10.38	$18.00	$33.92	$54.69	$66.46	$114.92	$270.69	$666.69
$200,000	$4.62	$7.38	$6.46	$7.38	$9.23	$13.85	$24.00	$45.23	$72.92	$88.62	$153.23	$360.92	$888.92
$300,000	$6.92	$11.08	$9.69	$11.08	$13.85	$20.77	$36.00	$67.85	$109.38	$132.92	$229.85	$541.38	$1,333.38
$400,000	$9.23	$14.77	$12.92	$14.77	$18.46	$27.69	$48.00	$90.46	$145.85	$177.23	$306.46	$721.85	$1,777.85
$500,000	$11.54	$18.46	$16.15	$18.46	$23.08	$34.62	$60.00	$113.08	$182.31	$221.54	$383.08	$902.31	$2,222.31

Additional benefit amounts are available in $10,000 increments to a maximum of $500,000

BlueCross BlueShield of Illinois

BENEFIT PROGRAM SUMMARY
CITY OF BERWYN - #F151642

A simple, economical way to plan for your and your family's future. The voluntary coverage is payroll deducted and sponsored by your employer at a conveniently cost effective rate. Most families depend upon each paycheck to pay expenses and plan for the future. In the unexpected event of death, life insurance provides immediate financial assistance for you and your family when it is most needed.

VOLUNTARY GROUP TERM LIFE / AD&D

Eligibility	All Eligible Active Full Time Employees
Voluntary Group Term Life Benefit: Employee	$10,000 - $500,000 in $10,000 increments.
Voluntary Group Term Life Benefit: Spouse	$5,000 - $250,000 in $5,000 increments, not to exceed 50% of the employee benefit.
Voluntary Group Term Life Benefit: Child(ren)	$2,500 - $10,000 in $2,500 increments (6 months to age 26).

Guarantee Issue - Employees

- Employees under age 60 who are not currently enrolled and waived coverage when they were first eligible for voluntary life may enroll for $50,000 in coverage without providing a medical questionnaire.
- Employees age 60-69 who are not currently enrolled and waived coverage when they were first eligible for voluntary life may enroll for $10,000 in coverage without providing a medical questionnaire.
- Employees currently enrolled may elect up to an additional $50,000 in coverage up to the GI without providing a medical questionnaire.

Dependents

- Spouses under age 70 and children who are not currently enrolled may enroll for $10,000 in coverage without a medical questionnaire.
- Spouses who are under age 70 and are currently enrolled may elect an additional $10,000 without providing a medical questionnaire.

Spouses age 70 and older are subject to medical underwriting requirements.

Employees and spouses who were declined coverage after submitting a medical questionnaire in the past under this plan or who are over age 69 will be subject to EOI requirements for all elected amounts.

Voluntary AD&D

You have the option of purchasing Voluntary AD&D coverage. However, Voluntary AD&D may not be purchased separately. You must apply for Voluntary Group Life insurance if you wish to select Voluntary AD&D coverage. Satisfactory Evidence of Insurability may be required for Voluntary Group Life insurance. If your application for life insurance is declined, no AD&D coverage will be issued.
Individual Plan – allows you to choose a benefit amount up to $500,000, in increments of $10,000.
Family Plan – allows you to insure your spouse and/or dependent children. The spouse benefit is equal to 50% of your benefit, and each child is covered for 10% of your benefit amount.

Note: Voluntary AD&D Benefit amounts for insured persons over the age of 69 will be equal to the following schedule: Age 70-74 (Principal Sum Equal to 65% of the benefit); Age 75-79 (45% of benefit); Age 80-84 (30% of benefit); and 85 and over (15% of benefit).

Waiver of Premium (Employee Only)	If an employee is unable to engage in any occupation as a result of injury or sickness for a minimum of 9 months, prior to age 60, premium will be waived for the employee's life insurance benefit until the employee is no longer disabled or reaches age 65, whichever occurs first.
Definition of Disability	Diagnosed by a doctor to be completely unable, because of sickness or injury to engage in any occupation for wage or profit or any occupation for which they become qualified by education, training or experience.
Accelerated Death Benefit (ADB)	Upon the employee's request, this benefit pays a lump sum up to 50% of the employee's Life insurance, if diagnosed with a terminal illness and has a life expectancy of 12 months or less. Minimum: $7,500. Maximum: $250,000. The amount of group term life insurance otherwise payable upon the employee's death will be reduced by the ADB.
Portability Feature; Conversion Privilege	Included.
Beneficiary Resource Services; Travel Resource Services	Included.
Exclusions	A one-year suicide exclusion applies to Voluntary Group Term Life.

BlueCross BlueShield of Illinois

VOLUNTARY GROUP ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) PROGRAM SUMMARY

Group AD&D is an additional death benefit that pays in the event a covered employee dies or is dismembered in a covered accident. AD&D benefit is 24-hour coverage.

AD&D Schedule of Loss*	Principal Sum
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of One Hand and One Foot	100%
Loss of Speech and Hearing	100%
Loss of Sight of Both Eyes	100%
Loss of One Hand and the Sight of One Eye	100%
Loss of One Foot and the Sight of One Eye	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Loss of Sight of One Eye	50%
Loss of One Hand or One Foot	50%
Loss of Speech or Hearing	50%
Loss of Thumb and Index Finger on Same Hand	25%
Uniplegia	25%

* Loss must occur within 365 days of the accident.

AD&D Product Features Included:

- Seatbelt and Airbag Benefits
- Repatriation Benefit
- Education Benefit

Exclusions - We will not pay any benefit for any loss that, directly or indirectly, results in any way from or is contributed to by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or
2. any infection, except a pus-forming infection of an accidental cut or wound; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted Accident; or
5. war, declared or undeclared, whether or not the Employee is a member of any armed forces; or
6. travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
7. commission of, participation in, or an attempt to commit an assault or felony; or
8. being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the Employee's licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
9. intoxication as defined by the laws of the jurisdiction in which the accident occurred or .08% blood alcohol content if the jurisdiction in which the accident occurred does not define detoxification. Conviction is not necessary for a determination of being intoxicated;
10. active participation in a riot. "Riot" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

BlueCross BlueShield of Illinois

Coverage Election Summary for EOI

To be completed by Group Administrator/Employer
Attach this form with the completed Employee Application and return to:

Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (800) 367-6401
Fax Number: (855) 691-7157

Complete all blanks and print clearly. Omitted information will cause consideration of coverage to be delayed.
*The effective date of coverage is the date the application is approved. Premium is due the first of the month following the approval date. **Group Administrator/Employer: Do not deduct premiums for any coverage subject to evidence of insurability until you receive final confirmation of approval.**

TO BE COMPLETED BY GROUP ADMINISTRATOR/EMPLOYER: (Print and submit with employee enrollment information.)			
Employer Name		Group Number	Account No. _____ Location No. _____
Employer's Street Address		City	State / Zip Code
Employer Contact Name	Business Phone Number	Business Fax Number	Email Address
Employee Name (first, middle initial, last) _____	Social Security Number _____	Alternate ID _____	Coverage Request for: □ Employee □ Spouse □ Dependent Child(ren)*

*Evidence of Insurability is not required for supplemental or voluntary dependent child term life coverage for total benefit amounts of $10,000 or less.

Earnings: _____ □ Hourly □ Weekly □ Monthly □ Annually	Employee Date of Hire:	Employee Date of Rehire:	

REASON FOR EOI: □ Amount over Guarantee Issue □ Late Enrollment □ Annual Enrollment □ Increase In Coverage □ Change in Status – Date _____ Reason: _____

Type of Coverage	**Current Amount In-Force (if any)**	**Additional Amount Requested**	**Total Amount Requested**
□ Basic Term Life	$	$	$
□ Supplemental/Voluntary Employee Term Life	$	$	$
□ Supplemental/Voluntary Spouse Term Life	$	$	$
□ Supplemental/Voluntary Dependent Child(ren) Term Life	$	$	$
□ Basic Short-Term Disability	$	$	$
□ Basic Long-Term Disability	$	$	$
□ Voluntary Short-Term Disability	$	$	$
□ Voluntary Long-Term Disability	$	$	$
□ Employee Critical Illness	$	$	$
□ Spouse Critical Illness	$	$	$
□ Dependent Child(ren) Critical Illness	$	$	$

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Dearborn Life Insurance Company

Evidence of Insurability Application
To be completed by the applicant
Return completed application and enrollment information to:
Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (800) 367-6401
Fax Number: (855) 691-7157

YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION TO BE CONSIDERED FOR COVERAGE.
Retain a copy of this application for your records.

EMPLOYEE INFORMATION SECTION: (Complete even if Employee is not applying for coverage.)					
Name First MI Last			□ Male □ Female	Date of Birth (MM/DD/YYYY)	
Social Security Number	Alternate ID	State of Birth	Country of Birth		
Home Mailing Address Street			City	State	Zip Code
Preferred Method of Contact	Employee Telephone Number		Cell Phone Number		
Work Phone Number	Email Address		Occupation		

SPOUSE INFORMATION SECTION: (Complete only if applying for Spouse coverage.)			
Name First MI Last		□ Male □ Female	Date of Birth (MM/DD/YYYY)
Social Security Number	Preferred Method of Contact	Spouse Telephone Number	Cell Phone Number
Work Phone Number	Email Address	State of Birth	Country of Birth

DEPENDENT CHILD(REN) INFORMATION SECTION:
Employee must complete this section for each child applying for Supplemental or Voluntary life insurance coverage amounts greater than $10,000.

Child 1 **Name**	First	MI	Last	□ Male □ Female	Social Security Number	Date of Birth (MM/DD/YYYY)
Child 2 **Name**	First	MI	Last	□ Male □ Female	Social Security Number	Date of Birth (MM/DD/YYYY)
Child 3 **Name**	First	MI	Last	□ Male □ Female	Social Security Number	Date of Birth (MM/DD/YYYY)
Child 4 **Name**	First	MI	Last	□ Male □ Female	Social Security Number	Date of Birth (MM/DD/ YYYY)

Dearborn Life Insurance Company

Evidence of Insurability Application
To be completed by the applicant
Return completed application and enrollment information to:
Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (800) 367-6401
Fax Number: (855) 691-7157

YOU MUST COMPLETE ALL PAGES OF THIS APPLICATION TO BE CONSIDERED FOR COVERAGE.
Retain a copy of this application for your records.

Employee Name _____ Social Security Number _____

HEALTH INFORMATION – Check either "Yes" or "No" to each question and circle the specific condition(s). Details to all "Yes" answers must be provided in section provided on page 3 below for any person applying for coverage. Omitted information will cause consideration of coverage to be delayed. Failure to provide full information or providing false information may result in denial of benefits and/or possible investigation for fraud.

HEALTH QUESTIONS SECTION: (Complete only if applying for coverage.)

1. Employee Height _____ feet _____ in. Weight ____ lbs. Spouse Height ____ feet ____ in. Weight ____lbs.

	Employee		Spouse	
2. **In the past 7 years,** has any person applying for coverage been diagnosed, treated, or given medical advice by a physician or an appropriately licensed clinical professional acting within the scope of their license for:	Yes	No	Yes	No
a. Congestive heart failure, heart attack, stroke, paralysis, cirrhosis of the liver, Hepatitis (B or C), emphysema, or chronic obstructive pulmonary disease (COPD):	☐	☐	☐	☐
b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the HIV virus:	☐	☐	☐	☐
c. Hodgkin's disease, leukemia, lymphoma, or malignant brain tumor?	☐	☐	☐	☐
d. Chronic kidney disease including failure, dialysis, transplant, or polycystic kidney disease?	☐	☐	☐	☐
e. Dementia, Alzheimer's disease, ALS (Lou Gehrig's Disease), Huntington's Chorea, multiple sclerosis, or muscular dystrophy?	☐	☐	☐	☐
f. Cancer, tumor, heart condition, high blood pressure, transient ischemic attack (TIA), aneurysm, neurological, or circulatory disorder?	☐	☐	☐	☐
g. Diabetes, systemic lupus, any autoimmune disorder, anemia or other blood disorder?	☐	☐	☐	☐
h. Gastrointestinal, respiratory, genitourinary, musculoskeletal, or connective tissue disorder?	☐	☐	☐	☐
i. Depression, anxiety, or any other mental/nervous disorder?	☐	☐	☐	☐
3. **In the past 5 years,** has any person applying for coverage received medical advice, sought treatment for drug or alcohol abuse, used any controlled substances (except those prescribed by a physician or other medical professional), been convicted or charged with operating a motor vehicle under the influence of drugs or alcohol?	☐	☐	☐	☐
4. **In the past 6 months**, has any person applying for coverage:				
a. been hospitalized, advised to have surgery, treatment, diagnostic tests, or other evaluation?	☐	☐	☐	☐
b. been prescribed long term maintenance medications for chronic conditions?	☐	☐	☐	☐
5. Has any person applying for coverage used cigarettes or other tobacco in the last 2 years?	☐	☐	☐	☐

EMPLOYEE HEALTH QUESTIONS SECTION: (Complete in addition to Health Questions Section above if applying for DISABILITY coverage.)

1. Are you pregnant? If "Yes", Date Due: _____ Any complications or problems?	☐	☐
2. **In the past 7 years,** have you been diagnosed or treated by a member of the medical profession for a disorder of the back, spine, neck, knee, bone or joint, arthritis, neurological disorder, fibromyalgia, chronic fatigue syndrome, or other musculoskeletal disorder?	☐	☐

DEPENDENT CHILD(REN) HEALTH QUESTIONS SECTION:
Employee must complete this section for each child applying for Supplemental or Voluntary life insurance coverage amounts greater than $10,000.

1. Child 1. Height _____ feet _____ in. Weight _____ lbs. Child 2. Height _____ feet _____ in. Weight _____ lbs.
Child 3. Height _____ feet _____ in. Weight _____ lbs. Child 4. Height _____ feet _____ in. Weight _____ lbs.

Dearborn Life Insurance Company

Evidence of Insurability Application
To be completed by the applicant
Return completed application and enrollment information to:
Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (800) 367-6401
Fax Number: (855) 691-7157

Employee Name _____ Social Security Number _____

DEPENDENT CHILD(REN) HEALTH QUESTIONS SECTION (Continued):

2. **In the past 5 years,** has any dependent child applying for coverage been diagnosed, treated, given medical advice by a physician or an appropriately licensed clinical professional acting within the scope of their license for: **Dependent Child(ren)** Yes No
   a. Diabetes, heart condition, cancer, cerebral palsy, cystic fibrosis, muscular dystrophy, autism, Down's syndrome, Intellectual and Developmental Disabilities, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the HIV virus?If "Yes", please provide name(s) of dependent child(ren). _____ ☐ ☐
   b. **In the past 6 months**, has any dependent child applying for coverage been hospitalized, required emergency room evaluation, been advised to have surgery, treatment, diagnostic tests or other evaluation? If "Yes", please provide name(s) of dependent child(ren). _____ ☐ ☐

PROVIDE DETAILS OF ALL "YES" ANSWERS FROM ALL HEALTH QUESTION SECTIONS ABOVE (If applicable). If additional space is required, attach a separate signed and dated sheet.

#	Person	Type of Condition	Dates	Hospitalized Yes or No	Surgery Yes or No	Treatment/ Medication	Current Meds/ Remaining Problems	Physician's Name, Address & Phone #

Dearborn Life Insurance Company

Evidence of Insurability Application
To be completed by the applicant
Return completed application and enrollment information to:
Dearborn Life Insurance Company
Attn: Medical Underwriting Department
P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (800) 367-6401
Fax Number: (855) 691-7157

AGREEMENTS AND AUTHORIZATION: "I" refers to the person(s) applying for insurance, signing below. I hereby represent that the statements and answers to the question(s) are, to the best of my knowledge and belief, full, complete, true and correctly recorded, and will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. I understand Dearborn Life Insurance Company shall not be liable for any claim arising prior to the date of approval of this application at Dearborn Life Insurance Company's Home Office.

To determine my eligibility for the coverages applied for, I authorize any physician, medical professional, practitioner, hospital, clinic, other health facility, medical or medically-related facility, medical provider, mental health professional, pharmacy or pharmacy benefit manager, laboratory, insurance company, the MIB, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to Dearborn Life Insurance Company's underwriting department its authorized representative(s), my medical records or that of my children, including information concerning advice, care or treatment for any condition, including but not limited to medical history, pharmaceutical history, drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases.

I further authorize Dearborn Life Insurance Company to disclose the information obtained in the consideration of my application for insurance to its reinsurers and the MIB, Inc., a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.
This authorization shall expire 24 months from the date it is signed. I understand and agree that:

- I may revoke this authorization at any time by written notice, but that such a revocation will have no effect on any actions taken by Dearborn Life Insurance Company prior to receipt of the revocation;
- Information provided pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule);
- I should retain a duplicate copy of this authorization for my own records;
- A photocopy of this authorization shall be as valid as the original;
- I have received a Disclosure Statement; and
- **Coverage will not become effective until Dearborn Life Insurance Company approves my application, provided that I am actively at work on that day;**
- **No premiums may be deducted by my Employer on amounts subject to evidence of insurability until a final decision regarding approval of coverage is received by my employer from Dearborn Life Insurance Company.**

I, as well as any other person authorized to act on my behalf or my personal representative, acknowledge the right upon request to obtain a true copy of this authorization from Dearborn Life Insurance Company.

If my answers on this application are incorrect or untrue, or if I refuse to sign this authorization, Dearborn Life Insurance Company has the right to deny benefits or rescind my coverage or that of my dependents, if applicable.

Signature of Employee (required) _____ Date Signed (MM/DD/YYYY) _____

Signature of Spouse (if requesting insurance) _____ Date Signed (MM/DD/YYYY) _____

Signature of Dependent Child (if requesting insurance and at least 18 years of age)

Child 1_____ Date _____ Child 2 _____ Date_____

Child 3_____Date _____ Child 4 _____ Date _____

GROUP LIFE BENEFITS

for

City of Berwyn

F151642-0001

Underwritten By

FORT DEARBORN LIFE INSURANCE COMPANY

FORT DEARBORN LIFE INSURANCE COMPANY

GROUP CERTIFICATE

Fort Dearborn Life Insurance Company
(A stock life insurance company)
Administrative Office: 1020 31st Street
Downers Grove, Illinois 60515-5591

Certifies that the holder of this Certificate, while entitled to insurance, is subject to all the terms and conditions contained in the Policy.

For all purposes of this Certificate, the Insured will be referred to as "you" or "your", and Fort Dearborn Life Insurance Company will be referred to as "we", "our" or "us".

THIS CERTIFICATE OF INSURANCE IS NOT AN INSURANCE POLICY. It does not form a part of the Policy, nor does it amend, extend or alter the coverage provided by the Policy. In case of a dispute, you should refer to the language contained in the Policy.

IF YOU SHOULD CEASE ACTIVE WORK FOR ANY REASON, please consult your Employer immediately to determine what arrangements may be made to continue your insurance benefits.

President

Secretary

Group Insurance Certificate
Non-Participating

SCHEDULE OF BENEFITS

POLICYHOLDER: CITY OF BERWYN

POLICY NUMBER: F151642-0001

MASTER POLICY EFFECTIVE DATE: As shown in the Master Application

CLASS OF INSUREDS	DEFINITION
1-01	All active full-time employees.

Basic Life Benefit: $25,000.

Benefit Reduction: Benefit reduces to 50% upon attainment of age 70. (All reductions in benefit will be calculated from the original amount.)

Basic AD&D Benefit: $10,000.

Benefit Reduction: Benefit reduces to 50% upon attainment of age 70. (All reductions in benefit will be calculated from the original amount.)

Benefit amounts may be subject to Guarantee Issue limits or Underwriting requirements as stated in the Master Application.

GENERAL PROVISIONS

ELIGIBILITY. The Application for the Policy states the eligibility requirements, including Classification, Exclusions, Date of Eligibility and Waiting Period. A person must be Actively at Work to be considered eligible.

If you have converted any part of your insurance under the Policy because you ceased being an Insured and you again become an eligible person your eligibility will be deferred until you submit Evidence of Insurability satisfactory to us.

YOUR EFFECTIVE DATE.

(a) If insurance is Noncontributory, insurance shall become effective on the Date of Eligibility.

(b) If insurance is Contributory, insurance shall become effective:

(i) on the date a person becomes eligible, provided that person both applies for insurance on or before the Date of Eligibility and agrees to pay the required contribution; or

(ii) on the date of request for insurance, if a person's request is made within the 31 day period after the Date of Eligibility and he/she agrees to pay the required contribution.

A request for insurance may be made by a person more than 31 days after the date of eligibility or a request may be made after insurance lapses because of failure to pay the required contribution when due. In these cases, the requesting person must:

(i) furnish Evidence of Insurability acceptable to us; and

(ii) agree to pay the required contribution.

(c) The following apply to both Noncontributory and Contributory insurance:

When Evidence of Insurability is required, insurance shall become effective on the first day of the insurance month which is the same as or which next follows the date we determine Evidence of Insurability to be acceptable.

If a person is not Actively at Work on the day prior to the date when he/she would otherwise become insured, insurance will become effective on the date of return to Active Work.

A person will be deemed Actively at Work on each day of paid vacation or scheduled day off on which he/she is not totally disabled, if he/she was Actively at Work on his/her last scheduled working day.

All requests for insurance are subject to our approval and must be made to the Policyholder in writing, on a form furnished by us.

CHANGES IN AMOUNTS OF INSURANCE/CLASSIFICATION. A change in the amount of insurance due to a change in your classification (or salary, if applicable) shall become effective on the date you become eligible for the change, as set forth in the Application if:

(a) you are Actively at Work; and

(b) you make the required contribution, if any, toward the premium payment.

If you are not Actively at Work on the day you would otherwise be eligible for the change, the change shall become effective on the date you are again Actively at Work.

BENEFIT PROVISIONS

PAYMENT OF BENEFITS. The amount of insurance as shown in the Schedule of Benefits will be paid upon receipt of due proof of your death.

OPTIONAL METHODS OF SETTLEMENT. Payment of benefits will normally be made in one lump sum. However, you may choose to have life insurance benefits paid in any other way approved by us. If you have not made an election for payment other than in a lump sum, the Beneficiary may elect benefits to be paid in any other way approved by us.

WAIVER OF PREMIUM IN THE EVENT OF TOTAL DISABILITY. Your amount of life insurance determined in accordance with the Schedule of Benefits will be continued without premium payment for one year from the date proof satisfactory to us has been received within the time specified below, that you are totally disabled and meet the policy requirements to receive this benefit. Satisfactory proof is a finding that:

(a) your disability has resulted from disease or accidental bodily injury;

(b) such disability has resulted in your complete inability to engage, for wage or profit, in any employment or occupation for which you are reasonably suited by education, training or experience;

(c) such disability began prior to your sixtieth birthday and while insurance is in force; and

(d) your total disability has existed continuously for at least six months prior to furnishing such proof to us.

The proof must be furnished to us no later than 12 months following the date of the last premium payment for you, and not later than 24 months following the date you became totally disabled.

Life insurance will be continued without premium payment for additional periods of one year if:

(a) you remain totally disabled; and

(b) proof of continuance of such total disability is furnished to us as often as required. After two years of total disability proof will not be required more often than once per year.

Insurance under this Waiver of Premium provision will end on the earliest of:

(a) the date you are no longer totally disabled; or

(b) the date you fail to submit to any required medical exam; or

(c) the date you fail to submit required proof of continuation of total disability; or

(d) the date you attain age 70 or retire, whichever occurs first. (Benefits will reduce as shown in the Schedule, while insurance is continued under this provision.)

STANDARD PROVISIONS

BENEFICIARY. Benefits for loss of life will be paid to the Beneficiary named by you. You may name a Beneficiary or may change a formerly named Beneficiary by filing a properly completed request with us. The request must be on a form and in a manner approved by us. A beneficiary designation or change request shall take effect when made, whether or not you are living at the time it is received by us. Any benefit payment made by us in accordance with the Policy, but before receipt of notice of a beneficiary designation or change will fully discharge our obligation for payment.

If two or more persons become entitled to benefits as Beneficiaries, and if you did not state otherwise, they shall share equally. If any such Beneficiary does not survive you, that share will pass to the surviving Beneficiary; or

If no Beneficiary is named or if the named Beneficiary does not survive you, then the benefits will be paid in the following order:

(i) to your spouse, if living; or

(ii) to your then living children, equally; or

(iii) to your surviving parents, equally; or

(iv) to your surviving brother(s) and sister(s), equally; or

(v) to your estate.

In the event the named Beneficiary is not living at the time of your death, we may pay an amount not to exceed Two Thousand dollars to any person who appears to us to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to your last illness or death.

If the Beneficiary is incapable of giving a valid release for payment, we shall have the option, and until claim is made by a duly named guardian of such Beneficiary, of paying the benefit in an amount not greater than Five Hundred dollars a month to the party who appears to have assumed the care and support of such Beneficiary.

Any payment made under this Provision will completely discharge us from further obligation for the amount paid.

ASSIGNMENT. An absolute assignment by you of all incidents of ownership of your life insurance will be permitted. Any such assignment will only take effect for us on the date it is received and approved at our Home Office. We assume no liability for the validity of any assignment. Collateral assignments, by whatever name called, will not be permitted.

ENTIRE CONTRACT. The Policy, the written Application made by the Policyholder and the individual applications, if any, form the entire contract between the parties.

INCONTESTABILITY. In the absence of fraud, all statements made by the Policyholder or you will be deemed representations and not warranties. No such representations will void the insurance or be used to deny a claim unless a copy of the instrument containing such representations is or has been furnished to you or your Beneficiary.

The validity of the Policy will not be contested, except for non-payment of Premium, after the Policy has been in force for at least two consecutive years from its Effective Date. No statement made by you will be used to contest the validity of the insurance with respect to the statement which was made, after such insurance has been in force for two consecutive years during your lifetime nor unless it is contained in a written application signed by you.

ACCELERATED DEATH BENEFIT - TERMINAL ILLNESS PROVISION

DEFINITIONS

"**Accelerated Death Benefit" (the Benefit)** means 50% of your Group Term Life Insurance Amount in force on the date that the Company receives proof, acceptable to the Company, that you are a Terminally Ill Insured.

"**Physician**" means a licensed practitioner, practicing within the scope of his/her license. A Physician must be someone other than you or your family member(s).

Terminally Ill Insured means an Insured who is expected to die within 12 months, due to a medical condition. Such Insured must be Actively-At-Work on the day prior to the Effective Date of their insurance coverage under theTerminal Illness Provision.

BENEFIT PAYMENT PROVISIONS

If you or your legal representative elects the Benefit and provides proof, acceptable to us that you are a Terminally Ill Insured, we will pay the Benefit, during your lifetime, in one sum to you. This amount is limited to a maximum of $150,000. The minimum amount available is $10,000. In no event may the Benefit plus the remaining amount of Group Term Life Insurance payable upon the Insured's death exceed the amount that would have been payable upon the Insured's death if the Group Term Life insurance had not been accelerated.

We retain the right to determine, at our sole discretion, if proof is acceptable to us.

The Benefit paid under this provision may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you or your beneficiary should consult a personal tax advisor to assess the impact of the Benefit.

Exceptions: The Benefit will not be payable:

(1) if you become a Terminally Ill Insured as a result of:

(i) attempted suicide while sane or insane; or

(ii) an intentionally self-inflicted injury; or

(2) if your Group Term Life Insurance benefit has been assigned; or

(3) if your Group Term Life Insurance benefit is payable to an irrevocable beneficiary including notification, to the Company, that such benefit or a portion of such benefit is to be paid to a former spouse as part of a divorce agreement. Fort Dearborn will not be liable for payment of a benefit in violation of a divorce or legal separation agreement if such notice has not been filed with us at our Home Office; or

(4) if you are required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or

(5) if you are required by a government agency to use this option in order to apply for, get or keep a government benefit or entitlement.

Part 1: ACCIDENTAL DEATH AND DISMEMBERMENT AND LOSS OF SIGHT PROVISION(II.)

INSURING CLAUSE

Subject to the Section - What We Do Not Pay," Benefits will be paid to You if You sustain any of the losses listed in the Table of Losses while insured under this Provision. These losses must:

1) Be the result of bodily injury caused solely by accident and independent of all other causes;

2) Occur within 90 days of the date of the accident; and

3) Be losses for which Proof of Loss is submitted within 180 days of the accident.

TABLE OF LOSSES

For the loss of:	**The amount of Payment will be**
Accidental Death Both hands or both feet Sight of both eyes One hand and one foot One hand and sight of one eye One foot and sight of one eye	THE MAXIMUM BENEFIT
One hand One foot Sight of one eye	ONE-HALF-THE MAXIMUM BENEFIT
Thumb and index finger of either hand	ONE FOURTH THE MAXIMUM BENEFIT

The amount of payment will be determined by the Maximum Benefit shown for this coverage in the Schedule of Benefits.

With respect to hands or feet, "loss" means actual severance at or above wrist or ankle joints; with respect to eyes, permanent and total loss of sight; with respect to thumb and index finger, complete severance of entire digit at or above joints.

No more than 100% of the Maximum Benefit will be paid for any one accident, no matter how many of the above listed losses occur as a result of that accident.

EVIDENCE OF INSURABILITY

You must meet the Evidence of Insurability provisions for the Life Insurance benefit before You may be insured for the AD&D benefit.

WHAT WE DO NOT PAY (EXCLUSIONS)

The Company does not pay for any loss that directly results from any of the following:

1) Any disease or infirmity of mind or body and any medical or surgical treatment thereof; or

2) Suicide or attempted suicide, while sane or insane; or

3) Any intentionally self-inflicted injury; or

Part 3: EDUCATION BENEFIT

INSURING CLAUSE

We will pay an Education Benefit to Your Dependent Student if Your death is the result of an accident for which the Accidental Death & Dismemberment Benefit is payable.

DEFINITIONS

"Student" means a Dependent who, on the date of Your death is:

1) A full-time post-high school student in a school of higher education; or

2) A student in the 12th grade but who becomes a full-time post-high school student in a school of higher education within 365 days after Your death.

"School of higher education" means an institution which:

1) Is legally authorized by the State in which it is located; and

2) Provides a program for either:

   a) Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or

   b) Gainful employment so long as such program is at least one year of training; and

3) Is accredited by an agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

AMOUNT OF BENEFIT

The Dependent Education Benefit for each Dependent Student shall equal the lesser of the Maximum Amount of Your Accidental Death & Dismemberment Benefit or $12,000.

PAYMENT OF BENEFIT

We will pay the Dependent Education Benefit in four equal annual installments. We will only pay one Dependent Education Benefit to any one Dependent Student during any one school year. If the Dependent Student is a minor, We will pay the benefit to the legal representative of the minor.

ACTION AGAINST COMPANY

No lawsuit or action may be brought to recover on this provision within 60 days after written proof of loss has been given. No lawsuit or action may be brought after three years from the time written proof of loss is required to be given.

EXAMINATIONS

We, at our own expense, will have the right to have a Physician or other medical or psychological professional We designate examine You as often as it may require whenever Your loss is the basis of a claim.

EFFECTIVE DATE

The Effective Date of this provision is the Effective Date of the Policy, unless another date is shown herein.

WHEN INSURANCE UNDER THIS PROVISION ENDS

Insurance under this provision ends on the earlier of the dates stated in your certificate for your life insurance or on the last day for which premium has been paid for insurance under this provision.

ADDITIONAL PREMIUM

There will be an additional premium due for insurance under this provision on each premium due date on and after the Effective Date of this provision.

*ERISA INFORMATION STATEMENT

The benefits described in your certificate and this ERISA Information Statement (collectively the "Summary Plan Description" a/k/a the SPD) are insured by a Policy issued by Fort Dearborn Life Insurance Company. This SPD describes the provisions of the Plan in effect as of the Effective Date of the Policy. It is not the intention of the SPD to cover all situations that may arise, but to provide you with a general understanding of your benefits. In the case of any item not covered by the SPD, or in the event of any conflict between the SPD and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from, this SPD.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy must also be approved in writing by an officer of Fort Dearborn Life Insurance Company (the "Insurer") and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company. The Insurer's services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits.

*<u>This ERISA addendum only applies if the Policy is part of or is an ERISA Plan.</u>

if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

a) request a review upon written application within 180 days of the claim denial;
b) request, free of charge, copies of all documents, records and other information relevant to your claim; and
c) submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Fort Dearborn will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, Fort Dearborn notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

Life Insurance Plans

A decision will be made by Fort Dearborn no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement of your right to bring a civil action on denial of your appeal.

Any denied claim may be appealed to Fort Dearborn for a full and fair review. You may:

a) request a review upon written application within 60 days of receipt of claim denial;
b) review pertinent documents; and
c) submit issues and comments in writing.

A decision will be made by Fort Dearborn no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.