Dearborn National™ **Administrative Offices:** **Enrollment and Change Form**
Downers Grove, Illinois | Dallas, Texas

Underwritten by Fort Dearborn Life Insurance Company

☐ New Enrollment ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Retiree

EMPLOYER / EMPLOYEE SECTION **BASIC LIFE**

Enrollment forms must be submitted directly to Dearborn National unless the group is self-administered. If the group is self-administered, submit enrollment forms to Dearborn National only if evidence of insurability is required

Employer: **Batavia Public Schools #101**	Group No: **F108498**		Location:		
Employee Name - Last	First	Middle Initial	Sex	Date of Birth	Date of Hire (full time)

Social Security No	Earnings	Job Title	Class

Home Address	City	State	Zip

Home Phone	Work Phone	Cell Phone

BENEFIT SELECTION - SUPPLEMENTAL LIFE

COVERAGE SELECTION: Your non-medical group insurance program may not include all 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.**

Supplemental Coverage (Select all that apply)	Requested Benefit Amount	Monthly Premium - Life & AD&D
☐ Supplemental Life & AD&D - Employee Your employer pays 0% of the premium for this coverage	Current Election: $ $20,000 $50,000 $100,000 $150,000 $200,000 Other _____	☐ Current Premium: $ ☐ $3.40 ☐ $8.50 ☐ $17.00 ☐ $25.50 ☐ $34.00 ☐ $0.17/$1,000 of coverage ☐ Waive Coverage
☐ Supplemental Life & AD&D - Spouse Your employer pays 0% of the premium for this coverage	Current Election: $ $20,000 $30,000 $50,000 Other _____	☐ Current Premium: $ ☐ $3.40 ☐ $5.10 ☐ $8.50 ☐ $0.17/$1,000 of coverage ☐ Waive Coverage
☐ Supplemental Life & AD&D - Child(ren) Your employer pays 0% of the premium for this coverage	Current Election: $ $2,500 $5,000 $7,500 $10,000	☐ Current Premium: $ ☐ $0.63 per family unit ☐ $1.25 per family unit ☐ $1.88 per family unit ☐ $0.17/$1,000 of coverage ☐ Waive Coverage

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	Social Security Number	Date of Birth	Relationship	Percentage
Primary					
Primary					
Contingent					
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 UNDERSTANT THAT IF I AM NOT ACTIVELY AT WORK ON THE EFFECTIVE DATE OF MY COVERAGE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I RETURN TO 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.

EMPLOYEE SIGNATURE _____ DATE _____