FORT DEARBORN LIFE
Insurance Company
Chicago, Illinois

Group Name _____

Group Number_____

Policyholder Change to be Completed by Employer

Administrative Offices: **Downers Grove, Illinois I Cleveland, Ohio I Dallas, Texas**

Employer: Please fax this form to: (312) 240-0143

For best results, use a black felt-tip pen and block-style lettering, to complete.

Do NOT mail enrollment card to FDL. Keep in employee file.

ACTION – ☐

SSN ☐☐☐ – ☐☐ – ☐☐☐☐

Effective Date of Change MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

Date of Hire MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

Date of Hire MONTH ☐☐☐, ☐☐☐.☐☐ ☐ Weekly ☐ Monthly ☐ Annually

Name (Complete Name field if changing name or adding an employee.)

LAST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ FIRST ☐☐☐☐☐☐☐☐☐☐ M.I. ☐

Gender ☐ Male ☐ Female

Dependent Life ☐ Add ☐ Remove

Dependent Change Reason ☐ Marital Status ☐ Child ☐ Other

Birth Date MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

Benefit Class ☐☐

Basic Life & AD&D ☐ Add ☐ Remove

STD Benefit ☐ Add ☐ Remove

LTD Benefit ☐ Add ☐ Remove

Supplemental Life/Amt ☐ Add ☐ Remove $☐☐☐,000

Supplemental AD&D/Amt ☐ Add ☐ Remove $☐☐☐,000

ACTION – ☐

SSN ☐☐☐ – ☐☐ – ☐☐☐☐

Effective Date of Change MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

Date of Hire MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

Date of Hire MONTH ☐☐☐, ☐☐☐.☐☐ ☐ Weekly ☐ Monthly ☐ Annually

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Dependent Life ☐ Add ☐ Remove

Dependent Change Reason ☐ Marital Status ☐ Child ☐ Other

Birth Date MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

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ACTION – ☐

SSN ☐☐☐ – ☐☐ – ☐☐☐☐

Effective Date of Change MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

Date of Hire MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

Date of Hire MONTH ☐☐☐, ☐☐☐.☐☐ ☐ Weekly ☐ Monthly ☐ Annually

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LAST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ FIRST ☐☐☐☐☐☐☐☐☐☐ M.I. ☐

Gender ☐ Male ☐ Female

Dependent Life ☐ Add ☐ Remove

Dependent Change Reason ☐ Marital Status ☐ Child ☐ Other

Birth Date MONTH ☐☐ / DAY ☐☐ / YEAR ☐☐

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STD Benefit ☐ Add ☐ Remove

LTD Benefit ☐ Add ☐ Remove

Supplemental Life/Amt ☐ Add ☐ Remove $☐☐☐,000

Supplemental AD&D/Amt ☐ Add ☐ Remove $☐☐☐,000

ACTION CODE

1. ADD EMPLOYEE
2. NAME CHANGE
3. SALARY CHANGE
4. ADDITION OF BENEFIT
5. CHANGE OF BENEFIT
6. REMOVE BENEFIT
7. TERMINATE EMPLOYEE
8. REINSTATE EMPLOYEE

If your plan requires Evidence of Insurability, please submit an Evidence of Insurability form.

If your employees wish to apply or make changes to Voluntary coverages, please FAX a copy of the completed enrollment form to the number shown above.