J. Sterling Morton High School / Business Office
5801 West Cermak Road, Cicero, Illinois 60804
Phone: (708) 780-2122 / lsolimeno@jsmorton.org

TO: All Eligible Active Full Time Employees

RE: Supplemental Life Insurance Applications

Attached is a packet needed when applying for the Supplemental Group Term Life / AD&D Policy through Dearborn National.

Supplemental Life Benefit Summary

Dearborn National

GROUP SUPPLEMENTAL BENEFIT PROGRAM SUMMARY
For J STERLING MORTON HIGH SCHOOL DISTRICT

The death of a family provider can mean that a family will not only find itself facing the loss of a loved one, but also the loss of financial security. With our Group Term Life plan, an employee can achieve peace of mind by giving their family the security they can depend on.

SUPPLEMENTAL GROUP TERM LIFE/AD&D

Eligibility	All Eligible Active Full Time Employees
Group Term Life/AD&D Benefit: Employee	Increments of $10,000 to a maximum of $1,000,000 or 6 times salary, whichever is less.
Guaranteed Issue Amount – Employee	$150,000
Group Term Life Benefit: Spouse	Increments of $5,000 to a maximum of $250,000, not to exceed 50% of the Employee's Supplemental Life Amount
Guaranteed Issue Amount – Spouse	The lessor of 50% of the employee's coverage or $50,000
Group Term Life Benefit: Child(ren)	$5,000 or $10,000 (age 6 months to 19 years (25 years if full-time student).
Age Reduction Schedule	Life and AD&D benefits reduce by 35% of the original amount at age 70 and further reduce to 45% at age 75. Employee benefits terminate at retirement. Spouse benefits terminate once the employee reaches age 70.
Employee Contribution	100%
Waiver of Premium	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.
Accelerated Death Benefit (ADB)	Upon the employee's request, this benefit pays a lump sum up to 75% of the employee's Life insurance, if diagnosed with a terminal illness and has a life expectancy of 24 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 (Life coverage)	Included.
Conversion Privilege (Life coverage)	Included.
Exclusions	One-year suicide exclusion applies to Supplemental Group Term Life coverage. AD&D exclusions are the same as Basic AD&D exclusions.

and/or terms under which the policy may be continued or discontinued. The policy may be cancelled by the insurer at any time. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.

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 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%
Loss of Sight of One Eye	50%
Loss of One Hand or One Foot	50%
Loss of Thumb and Index Finger of Same Hand	25%

* Loss must occur within 365 days of the accident.

AD&D Product Features Included:

- Seatbelt and Airbag Benefits
- Repatriation Benefit
- Education Benefit
- Spouse Training Benefit
- Day Care Benefit

Exclusions - We will not pay any benefit for any Loss resulting from or caused by:

1. Any disease or infirmity of mind or body and any medical or surgical treatment thereof; or
2. Any infection, except an infection of an accidental injury; or
3. Suicide or attempted suicide, while sane or insane; or
4. Any intentionally self-inflicted injury; or
5. Travel or flight in a non-commercial 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
6. While 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 a licensed physician and used in the manner prescribed. This limitation does not apply if the influence was involuntary or unintentional. Conviction is not necessary for a determination of being under the influence; or
7. Direct result of the insured's 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 intoxications. Conviction is not necessary for a determination of being intoxicated; or
8. 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, with a common intent and whether or not damage to a person or property or unlawful act is the intent or the consequence of such disorder.

We will not pay any benefit for Loss of life resulting from or caused by war or act of war, if the cause of death occurs while the Insured is serving in the military, naval or air forces of any country, combination of countries or international organization, provided such death occurs while in such forces or within six months after termination of services in such forces.

Application for Supplemental Life (4 pages)

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) 451-0271
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) 451-0271
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.

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P.O. Box 7072
Downers Grove, IL 60515

Phone Number: (800) 451-0271
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 #

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Phone Number: (800) 451-0271
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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 _____

Beneficiary Form

BENEFICIARY DESIGNATION FORM

Dearborn National

Underwritten by Dearborn National Life Insurance Company

Return to Dearborn National 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
J. Sterling Morton High School District 201	

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. **DEARBORN NATIONAL 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

Evidence of Insurability

Coverage Election Summary for EOI

To be completed by Group Administrator/Employer

Attach this form with completed Employee Application

Dearborn Life Insurance Company™

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) 451-0271
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 Dearborn Life Insurance Company's 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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