

AGREEMENTS & AUTHORIZATION – Please read carefully before signing.

I, the undersigned applicant(s), have read and agree that the statements and answers are furnished in support of my application and are complete, true and correctly recorded to the best of my knowledge and belief. Except where specifically provided in the Group Policies, The State of Tennessee and Fort Dearborn Life Insurance Company (FDL) shall not be liable for any claim on account of illness, injury, or death, the cause of which arose or commenced prior to the effective date of my coverage.

I understand that coverage will be approved or denied only for those individuals listed on this application. Furthermore, I understand and acknowledge that FDL shall make the determination with regard to approval of my application. Finally, I understand and acknowledge that FDL’s determination cannot be appealed to The State of Tennessee, and that my application fee is not refundable.

I acknowledge receipt of the Disclosure Statement (see below), and understand that coverage will not become effective prior to the approval date specified by The State of Tennessee. I also understand that incorrect or untrue answers on this application may result in rescission of my coverage or that of my dependents or denial of any claims and may be cause for expulsion for The State of Tennessee Group Insurance Program.

I understand and agree that:

- This authorization is voluntary and that my signature is required in order for FDL to consider this application and to make a determination on whether to accept and issue the coverage(s) applied for herein.
- If I refuse to sign this authorization, FDL has the right to deny my request for coverage or that of my dependents, if applicable.
- I may revoke this authorization at any time in writing and that such a revocation will have no effect on any actions taken by FDL prior to receipt of the revocation.
- Information disclosed pursuant to this authorization may be redisclosed and is no longer protected by the federal privacy laws.
- All correspondence regarding coverage for those individuals listed on this application will be sent to the employee.
- I should retain a duplicate copy of this authorization for my own records.
- A photocopy or facsimile of this authorization shall be as valid as the original.
- This authorization shall expire 24 months from the date it is signed.

I, as well as any 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 FDL.

To determine my eligibility for the coverages applied for, I authorize any medical professional, hospital, medical facility, medical provider, insurance carrier, the MIB Group, Inc., or any Covered Entity or Health Plan as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to disclose to FDL’s underwriting department or its authorized representative(s) any information relating to me or my children concerning advice, care, or treatment for any health condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV (AIDS Virus) or other sexually transmitted diseases. I further authorize FDL to disclose the information obtained in the consideration of my application for insurance to the MIB Group, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

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.

_____	_____	(____) _____	(____) _____
Signature of Employee	Date	Daytime phone	Evening phone
_____	_____	(____) _____	(____) _____
Signature of Spouse (if requesting insurance)	Date	Daytime phone	Evening phone
_____	_____		
Signature of Dependent Child (if requesting insurance and of age of majority 18-24)	Date		

REMEMBER: You must complete this application in its entirety to be considered for coverage. Return this application, with a money order or cashier’s check in the amount of \$75 (**personal checks WILL NOT be accepted**), payable to Fort Dearborn.

Fort Dearborn Life Insurance Company
Administrative Offices
38500 Eagle Way
Chicago, IL 60678-1385
Phone: 1-800-451-0271

Please detach the Statement of Disclosure below and retain with your insurance records.

Fort Dearborn Life Insurance Company – Chicago, Illinois

STATEMENT OF DISCLOSURE

To assist us in processing the Application, your signature on the Agreements and Authorizations section of the Application for Late Enrollment to the Health Plan authorizes information concerning proposed insureds to be released relative to each person’s insurability. You or your personal representative are entitled to receive a copy of this authorization.

Information regarding your insurability will be treated as confidential. Fort Dearborn Life Insurance Company or its designated representative(s) may, however, make a brief report thereon to the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies which operates as an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB’s file you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number 866-692-6901 (TTY 866-346-3642).

Fort Dearborn Life Insurance Company or its designated representative(s) may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.