

PLEASE PRINT IN INK

Employee Last Name		First	Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security Number	
Date of Birth	Height Ft. In.	Weight (lbs.)	Date of Hire	Occupation	Location	Salary \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Mthly <input type="checkbox"/> Ann
Home Address — No. And Street Name				City,	State	Zip	Home Phone #: Work Phone #:

EMPLOYEE VOLUNTARY TERM LIFE and AD&D

Select the plan best for you:

- Plan 1: 1 times your annual salary (100%) **Volume \$ _____ I do not apply.
- Plan 2: 2 times your annual salary (200%)
- Plan 3: 3 times your annual salary (300%)
- Plan 4: 4 times your annual salary (400%) Monthly Premium: \$ _____
- Plan 5: 5 times your annual salary (500%)

**Round your annual salary to the nearest \$25,000; maximum \$500,000.

If selecting Employee Voluntary Term Life and AD&D more than 30 days past your initial eligibility date, please complete the Health Statement on the reverse side.

SPOUSE SUPPLEMENTAL TERM LIFE

- 50% of your Employee Voluntary Term Life amount, rounded to the next \$1,000 if not an exact multiple of \$1,000.
- ***Volume: \$ _____ I apply
 I do not apply
- Monthly Premium: \$ _____

***The Spouse's Supplemental Term Life volume cannot exceed \$100,000.

If selecting Spouse Supplemental Term Life coverage more than 30 days past the initial eligibility date, please complete the Health Statement on the reverse side.

CHILD(REN) SUPPLEMENTAL TERM LIFE

Select the plan best for you:

- Plan 1: \$ 2,500 Plan 3: \$ 7,500 Monthly Premium: \$ _____
- Plan 2: \$ 5,000 Plan 4: \$ 10,000 I do not apply

The Child(ren) Supplemental Term Life volume for any dependent cannot exceed 50% of the Employee's Term Life amount.

If selecting Child(ren) Supplemental Term Life more than 30 days past the initial eligibility date, please complete the Health Statement on the reverse side.

VOLUNTARY ACCIDENT INSURANCE (VAI)

Select the benefit plan and an amount of coverage best for you. Select an amount of coverage from \$25,000 up to \$300,000, in increments of \$10,000. Amount of coverage selected cannot exceed 10 times your annual salary.

- Plan A: Employee Only (100%) Volume: \$ _____
- Plan B: Employee (100%) and Spouse (50%)
- Plan C: Employee (100%) and Spouse (100%) Monthly Premium: \$ _____
- Plan D: Employee (100%) and Child (10%)
- Plan E: Employee (100%), Spouse (50%), and Child (10%) I do not apply
- Plan F: Employee (100%), Spouse (100%), and Child (10%)

If selecting VAI more than 30 days past the initial eligibility date, please complete the Health Statement on the reverse side.

The following beneficiary designation(s) are applicable to the Employee Term, AD&D, and VAI coverage(s) applied for in this application.

Primary Designation:	First Name	Initial	Last Name	Relationship	Birthdate
Designation:	_____				
Contingent Designation:	_____				

The beneficiary for Spouse and Child(ren) Supplemental Term Life and VAI coverage(s) is, in all cases, the Employee.

I state the information given as a part of my Application is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me in this application including the Health Statement on the reverse side will invalidate my coverage(s) and that all statements made by me shall be deemed representations and not warranties. I authorize my Employer to deduct from my wages or salary my portion, if any, of the premiums as they become due. I agree that my Employer acts as my agent in all dealings herein and my coverage(s) are subject to any future amendments to the Contract(s)/Policy(ies). I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity to give FDL, upon request, any information covering the health condition of any person included under coverage whenever the information is considered necessary by FDL for proper disposition of this application or of a claim submitted for payment.

Employee Signature: _____ Date: _____