GUIDELINES FOR IMPAIRED RISK UNDERWRITING

1. The applicant must be working at his occupation and must have been working "full time" for at least the past year;

2. We will then review his medical condition, medication, status of condition, age, type of employment and other pertinent data;

3. Basically, what we are looking for is the hard working, diligent person who may be uninsurable, but is able to work full time without losing time from his profession or job and is not chronically ill;

4. We are well aware that we may have a high claim ratio on this type of business. However, it is our feeling that by carefully underwriting the applicants, utilizing graded benefits and rated premiums, we can insure many of your problem cases;

5. The three major areas of concern to us are (A) back problems (B) chronic pulmonary problems and (C) mental disorders. These three areas are the most difficult to underwrite and, in most cases, will depend primarily on the Attending Physician Statement (APS) supplied for the applicant;

6. In all questionable cases, an APS will be required;

7. Do not attempt to write an applicant who you feel will present an immediate claim. Try to screen all your applicants well.

It is impossible to say that we can accept each and every condition. Some risks we will consider are listed below:

Abscesses
Adhesions
Alcoholism
Amputations
Angina Pectoris
Arteriosclerosis
Arthritis
Asthma
Bells Palsy
Bronchitis
Cancer
Cerebral Vascular Accident
Cholesterol (High)
Concussion
Colitis
Convulsions
Coronary By-Pass-Surgery
Coronary Occlusions
Cystitis
Deafness
Deformity
Diabetes
Diverticulitis
Duodenal Ulcer
Encephalitis
Epilepsy
Eye Disorder
Fistula
Fracture
Gall Bladder Disorder
Ganglion
Gastritis
Genitourinary Disorder
Glaucoma
Glycosuria
Gout
Hearing Impairment
Heart Attack
Hemophilia
Hepatitis
Hernia
High Blood Pressure
Ileitis
Kidney Stones
Low Blood Pressure
Meniere's Disease
Multiple Scherosis
Murmur - Heart
Nephrectomy
Nephritis
Nervous Disorders
Osteomyelitis
Overweight
Paralysis
Parkinson's Disease
Peripheral Vascular Disease
Pernicious Anemia
Phlebitis
Pleurisy
Polio
Polyps
Prostatitis
Purpura
Pyelitis
Regional Ileitis
Rheumatic Fever
Sinusitis
Stroke
Snycope or Vertigo
Transurethral Resection
Tuberculosis
Tumors or Cysts
Ulcers
Underweight
Urinary Stone
Variocele, Hydrocele
Variose Veins
Vertigo or Syncope

INELIGIBLE RISKS:

Car Washers
Domestics
Explosive Handlers
Furnace Personnel
High Window Cleaners
Judo & Karate Instructors
Kitchen Help
Migratory Workers
Oil & Natural Gas Workers
Powering Splicers
Racing Drivers
Rodeo Riders
Steeple Jacks
Street Vendors
Structural Iron Riggers
Taverns - Non-Mgmt. Personnel
Test Pilots
Tree Toppers
Tower Erectors

LIMITATIONS / EXCLUSIONS / INDIVIDUAL TERMINATIONS

- **Pre-existing conditions not covered for the first 24 months, unless disclosed on the application, and not excluded by waiver.**
- **Loss caused by war, declared or not, or while in the armed service of ancountry.**
- **Loss caused by normal pregnancy, including childbirth or elective abor tion, except when loss is caused by complications of pregnancy.**
- **Loss caused by intentionally self-inflictedinjury while sane or insane.**
- **Loss caused by engaging in a felony, or in resisting or fleeing arrest.**
- **Loss caused by the voluntary taking of poison or inhaling of gas, or while under the influence of alcohol, drugs, narcotics or barbiturates, except as prescribed by a physician.**
- **Loss for which payment is made under any Workmans' Compensation, Employer's Liability or Occupational Disease Law.**
- **Reduced benefit for mental and nervous disorders. One half of the monthly benefit for up to six (6) months.**
- **Coverage will terminate when you fail to pay your premium, you retire or cease to actively per form the material and substantial duties of your occupation, or upon attainment of age 70.**
- **Some provisions, benefits, exclusions or limitations listed herein may vary depending on your state of residence.**

FIDELITY SECURITY LIFE INSURANCE COMPANY

Kansas City, Missouri
A STOCK COMPANY

DISABILITY INCOME

Rates and Policy Information

GRADED BENEFIT PROGRAMS

UP TO
$8,000
MONTHLY INCOME

Plus these outstanding features

- ❑ Most pre-existing conditions are covered when listed on application and policy is issued!!
- ❑ Benefits up to 60% of earned income.
- ❑ You can not be singled out for a rate increase.
- ❑ Most occupations accepted.
- ❑ Coverage cannot be terminated due to individual claims.
- ❑ No medicals or bloodwork required.
- ❑ Own occupation covered for up to 24 months.
- ❑ Waiver of premium included.

NOW COVERAGE FOR THE
IMPAIRED RISK CLIENT

33% Of stated monthly benefit if disability occurs during first policy year.

66% Of stated monthly benefit if disability occurs during second policy year.

100% Of stated monthly benefit if disability occurs after second policy year.

Underwritten and Administered by:
Fidelity Security Life Insurance Co.
Kansas City, Missouri

Marketed by:
Insurance Management International
Deerfield Beach, Florida

3/98

Sponsored by: Consumers of America Group Insurance Trust

GRADED DISABILITY BENEFITS

The "Executive Platinum Plan"
GRADED BENEFIT DISABILITY

Graded Benefit Disability
Impaired or Substandard Risk
Professionals or Executives with Income in excess of $40,000
Issue Ages 18-63
90 Day Elimination Period
* 5 Year Benefit Period - Accident or Sickness
$2,000 Monthly Benefit - Minimum
$8,000 Monthly Benefit - Maximum
60% of Income - Integrated with other companies
$50.00 Annual Policy Fee

Issue Age (Last Birthday) Male or Female	Annual Premium Per $100 Monthly Benefit - 90 Day Elimination Period 5 / 5 Year Benefit
18-29	$70.00
30-39	$80.00
40-49	$87.00
50-59	$137.00
60-63	$182.00

Modal Factors: S / A .52
Quarterly .265 Monthly .091

The "Executive Silver Plan"
GRADED BENEFIT DISABILITY

Graded Benefit Disability
Impaired or Substandard Risk
Professionals or Executives with Income in excess of $20,000
Issue Ages 18-63
30 Day Elimination Period
* 2 Year Benefit Period - Accident or Sickness
$ 500 Monthly Benefit - Minimum
$8,000 Monthly Benefit - Maximum
60% of Income - Integrated with other companies
$50.00 Annual Policy Fee

Issue Age (Last Birthday) Male or Female	Annual Premium Per $100 Monthly Benefit - 30 Day Elimination Period 2 / 2 Year Benefit
18-29	$58.00
30-39	$66.00
40-49	$72.00
50-59	$114.00
60-63	$152.00

Modal Factors: S / A .52
Quarterly .265 Monthly .091

* For Disability commencing on or after age 65, the benefit Period is reduced by one-half.

DISABILITY INCOME
Underwriting Guide

Applicants for disability income coverage should be full time employees. The proposed insured's occupation and duties should always be described in as much detail as possible on the application. Job titles are not always indicative of the skills, training, or education necessary or of the job's physical requirements, which is why the duties should be recorded specifically. Use phrases such as "supervisory duties only" or "office duties only" when appropriate.

When listing medical history be as complete as possible. Include any pertinent information regarding applicant's health history as well as names and addresses of physicians and hospitals.

Since we aggressively underwrite all applications on a non-medical basis, it is imperative that we have as much medical information from the agent as is possible. Please forward to us all information you or your client may have, i.e., medical reports, test results, physician's letters.

The Graded Benefit Impaired Risk Disability Policy is designed primarily for the person who is uninsurable due to a medical or occupational problem. The policy may also apply to the person who has a ridered policy and desires standard coverage.

INSTRUCTIONS TO AGENTS

All Premium Checks Must Be Made Payable To Fidelity Security Life Insurance Company. Do Not Make Check Payable To The Agent Or Leave Blank.

1. Submit all applications within 14 days of application date.
2. All face amounts must be in multiples of $100.
3. Do not solicit business on any currently hospitalized person.
4. Do not solicit business on any individual you have reason to believe is suffering from a terminal illness.
5. Do not solicit business on individuals who are unemployed because of health or medical reasons.
6. The full initial premium must be submitted with application.
7. Annual premium of $300 or less must be paid annual mode only.

FIDELITY SECURITY LIFE INSURANCE COMPANY

Kansas City, MO

Policy No.

APP/DISABILITY
GRADED BENEFIT

I hereby apply for a Non-Participating Policy

1. (a) Full Name of Proposed Insured	(b) Home Telephone Number	Social Security No.

(c) Sex	(d) Marital Status	(e) Height? Feet In.	(f) Weight? Lbs.	(g) Date of Birth Mo. Day Yr.	(h) Birth Place	(i) Age	Send Notice to: R ☐ B ☐

2. Residence Address with Zip Code

3. Business Address with Zip Code Name of Employer

4. Occupation (Job Title) Duties Earned Annual Income $

5. Plan of Insurance: Graded Benefit Disability Income _____ Monthly Benefits 1st Policy Yr. 33%
2nd Policy Yr. 66%

6. ☐ Disability Income $_____Mo. Benefit Thereafter
☐ Benefit Period_____Yr. Acc._____ Yr. Sickness After the 2nd Policy Yr. 100%
☐ Elimination Period_____Day Acc. _____Day Sickness Total Mode Premium $_____

7. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Amount paid with application $_____

8. Is the Proposed Insured gainfully employed outside the home for a minimum of 30 hours per week and has he been so for the past year? YES_____ NO_____
If NO, Please explain_____

9. Has the Proposed Insured received medical advice or been confined to a hospital, nursing home or similar establishment or been disabled within the last 12 months? YES____ NO____
Have you ever been treated for: ___ Condition of the back ___ Heart ___ Brain ___ Liver ___ Kidneys ___ Lungs ___ Cancer ___ Diabetes ___ Arthritis

10. Has the Proposed Insured ever made claim for or received benefits for disability from any source? YES_____ NO_____

11. Has the Proposed Insured ever been tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? YES____ NO____

12. If "YES" to above #9, #10 & #11, please give reason, dates, hospital and doctor's name and addresses:

_____

_____

_____

Disability Income Insurance in Force: (If none, so state) Is replacement intended YES_____NO_____
If "YES", please explain _____

Company Name	Mo. DI	Ben. Period	To be Replaced or Changed	Policy Number
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Do you understand and agree that under the terms of any accident and health policy hereby applied for, any indemnity for loss of time shall commence (a) with the _____day of any period of disability due to accident (b) with the ____ day of any period of disability due to sickness, and not before?

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I have read the foregoing answers and state that they are full, complete and true, to the best of my knowledge and belief, and may be relied upon as the basis for any contract which may be issued on account of this application. These statements are to be considered representations and not warranties.

Dated at _____ this _____ day of _____, 19_____

Witnessed by X_____ X_____
Signature of Witness Signature of Proposed Insured

X_____
Signature of Owner/Applicant if other than Proposed Insured

I have received and read a copy of the Pre-Notice which describes how information is obtained and used by Fidelity Security Life Insurance Company. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or the Medical Information Bureau, Inc. that has any records or knowledge of me or my health {or my dependents health}, to give to Fidelity Security Life Insurance Company, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. A photographic copy of this authorization shall be a valid as the original. I agree this authorization shall be valid for two years form the date shown below.

X_____ X_____

Witness Date Proposed Insured

STATEMENT OF SOLICITING AGENT

How well and how long have you known the Proposed Insured? _____

Soliciting Agent _____

Taxpayer I.D. Number _____

PROPOSED INSURED'S ADDRESSES AND SOCIAL SECURITY NO.

(a) Residence Address? _____
(Print) Street and No. or P.O. Box No. City State Zip Code

(b) Business Address? _____

(c) Social Security No. _____

Send Notices:
☐ Residence
☐ Business

PERSONAL HISTORY INTERVIEW TELEPHONE INFORMATION

PROPOSED INSURED _____ Date _____
(Please Print)

Since the Proposed Insured may be contacted by the Fidelity Security Home Office, what is the most convenient time frame (between 8:00 a.m. and 7:00 p.m. EASTERN TIME) when he/she may be reached by phone?

Telephone Number: Home (Area) _____ (Number) _____ (Time) _____

Business (Area) _____ (Number) _____ (Time) _____

(Extension) _____

Has the Proposed Insured been informed that he/she may be contacted by phone? ☐ Yes ☐ No

COMMENTS:

Soliciting Agent or Broker _____
(Please Print)

PRE-NOTICE

Although your application is our main source of information, we at Fidelity Security Life Insurance Company may also collect or verify information pertaining to age, occupation, physical condition, health history and avocations by contacting various individuals or organizations by correspondence, telephone or personal contact. It may be necessary for us to share information we obtain with an individual or organization related to the medical or insurance industry or with an individual performing a function for us without your express written authorization.

Information regarding your insurability will be treated as confidential. Fidelity Security Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates 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 each company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Fidelity Security Life Insurance Company or its reinsurers may also release information from 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

93-22714 Rev 0810

FIDELITY SECURITY LIFE INSURANCE COMPANY

HIPAA AUTHORIZATION

I have received and read a copy of the Pre-Notice which describes how information is obtained and used by Fidelity Security Life Insurance Company. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, Inc. (MIB), IntelliScript, or other organization or institution that has any records or knowledge of me or my {or my dependents'} physical or mental health, including significant history, findings, diagnoses and treatment or nonmedical information, such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications of insurance, to give to Fidelity Security Life Insurance Company, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Fidelity Security Life Insurance Company.

Fidelity Security Life Insurance Company or its authorized representatives may release to its plan administrators, business associates, other insurance companies, MIB, or others whom I authorize in writing, information covered by this authorization. I authorize Fidelity Security Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

I agree this authorization shall be valid for two years from the date shown below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64141-8131, Attention: Privacy Officer. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Fidelity Security Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand I will receive a copy of this authorization.

Signature of Proposed Insured _____ Month/Day/Year _____

Printed Name of Proposed Insured _____ Date of Birth _____

City _____ State _____

Premium Receipt - - Do Not Detach Unless Full First Premium Is Paid With Application

Received from _____

The sum of $_____

For the full first premium specified in the application for insurance in the Fidelity Security Life Insurance Company which bears the same date as this receipt. The insurance under the Policy for which application is made will be effective on the date aproved by the Company. If the Proposed Insured is not insurable and acceptable, the Company will refund all premiums paid to date by the Proposed Insured. This receipt will be void if given for check or draft which is not honored on presentation.

Do not make check payable to agent or leave payee blank.

_____, 20_____

Agent_____

AUTHORIZATION TO COMPLY WITH HIPAA PRIVACY REQUIREMENTS

In connection with an application for insurance, for underwriting and claim purposes, I authorize:

- Any medical practitioner or facility or related entity; any insurer; The Medical Information Bureau, Inc. (MIB); any employer; group policyholder; contract holder, or any benefit plan administrator to give Fidelity Security Life Insurance Company (the "Company"), or **Risk Insurance and Reinsurance Solutions, Inc**., who is acting on behalf of the Company in this regard:
  - Personal information and data about me;
  - Medical information, records and data about me, including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - Information, records and data about me related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR Part 2;
  - Information, records and data about me related to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
  - Information, records and data about me related to mental illness, other than psychotherapy notes.
- The Company to re-disclose information, records and data received pursuant to this Authorization about me as authorized by me in writing or as otherwise permitted by applicable law.
- The Company, or any third party acting on behalf of the Company in this regard, to request and obtain consumer, investigative consumer or motor vehicle reports about me.
- Any employer, business associate, financial institution, or government agency to give the Company, or any third party acting on behalf of the Company in this regard, any information or data that it may have about my occupation, avocations, driving record, finances, character, reputation and aviation activities.
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to the MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR Part 2, once disclosed to the Company, may no longer be covered by those laws or regulations.
- Information obtained pursuant to this Authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- I may be asked to be interviewed if an investigative consumer report is ordered. Please call me at ( ) _____, time: _____ if such a report is ordered.
- Information related to HIV test results will only be disclosed as permitted by applicable law.
- This Authorization will end 30 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to Fidelity Security Life Insurance Company, Attn: HIPAA Privacy Law Compliance Officer, 3130 Broadway, Kansas City, Missouri 64111 and advising the Company that I have revoked this Authorization. Revocation may result in rejection of the application or in denial of coverage or a claim for benefits. Any action taken before the Company has received my revocation will be valid.
- **I understand that I will receive copy of this authorization.**

REVOCATION: You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit at Risk Insurance 1111 Brickell Ave., #2600 Miami, FL 33131. Your cancellation will not affect information that was released prior to receipt of the written request.

A photocopy of this form is as valid as the original form.

Signature of Proposed Insured: _____ Date: _____

Printed Name of Proposed Insured: _____

Date of Birth: _____

Automatic (ACH) premium payment authorization form

As a service to our customers, this form may be used in lieu of submitting monthly checks.

To enroll in the Automatic Payment Plan:
1. Complete the authorization form below.
2. Attach a voided check (for checking accounts)
3. Send both items by fax: *(954) 642-2521* or by mail: *Risk Insurance, 1111 Brickell Avenue, Ste. 2600 , Miami, FL 33131*

Please pay your first premium by check: *Please pay your first Premium by check even if you decide to enroll in an Automatic Payment Plan*. Once your request is processed, Automatic deductions will appear on your bank statement within 3 days of the Due Date (1st, 2nd or 3rd of the month.).

OR please draft initial premium from my checking account **___ Monthly ___Quarterly ___Semiannual ___Annual**

Draft Date 1st ___ 15th___ of the month.

Processing time: We will process your account for automatic deduction as soon as possible after we receive your form. Typically allow 30 days to process your request. *In the meantime please make your regularly scheduled payments by check when you receive a premium notice until you receive a premium notice that indicates "Do not mail your payment - balance will be automatically deducted on the due date".*

I hereby authorize Fidelity Security Life Insurance Company (FSL) to initiate premium deductions from the bank account indicated below. I further authorize the bank named below to debit my account for those payments. Recurring debits shall be made each month in an amount equal to the premium amount due.

POLICYHOLDER INFORMATION

First Name:_____ **Last Name:**_____ **Policy #:** _____

Address: _____

City:_____ State:_____ Zip: _____

Home Phone #:_____ Mobile Phone #:_____ Email address for notifications:_____

BANK ACCOUNT INFORMATION

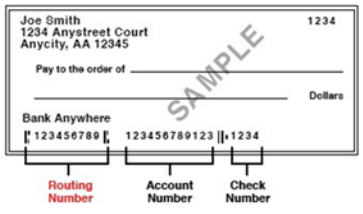
Name on Account: _____

Bank Name: _____ Account Type: ☐ Checking Account ☐ Savings Account

Bank Account Routing / Transit Number*: _____
*This is typically a nine digit number separated by a bar and a colon |: 123456789 |:

Bank Account number:_____

For accurate processing, please attach a voided check



Signature of Bank Account Holder:_____ Date: _____

You may cancel the Automatic Payment Plan at anytime by notifying in writing Fidelity Security Life Insurance Company or Risk Insurance and Reinsurance Solutions. To initiate ACH the policy must be current on its premium payments. You must maintain a bank balance sufficient to honor charges presented for payment. If you change banking arrangements, please fill in another authorization form for processing.