Marketed By: **Risk Insurance and Reinsurance Solutions Inc.**	**Application for Individual Disability Income Insurance**	**Fidelity Security Life Insurance Company ®** **3130 Broadway** **P.O. Box 418131** **Kansas City, MO 64141-8131** **(herein called "the Company")**

Applicant Information

1. Full Name (First, Middle, Last)		
2. Gender: ☐ Male ☐ Female	**3.** Date of Birth	**4.** State of Birth
5. Marital Status	**6.** Age	
7. Residence Address		
City	State	Zip
8. Do you want to add a secondary address? ☐ Yes ☐ No		
Secondary Address		
City	State	Zip
9. Mobile Phone	**10.** Email Address	**11.** Social Security Number

Employment Information

12. Employer Name:	
13. Business Address	
City/State/Zip	Phone No.
14. Have you been continuously actively-at-work on a fulltime basis without medical restrictions performing your usual and customary duties during the past 90 days? ☐ Yes ☐ No	
15. Number of hours you are working per week: _____	**16.** How long have you held this position? _____
17. Primary Occupation:	**18.** What percentage of your duties includes physical activity (i.e., climbing, crouching, lifting, etc.)? _____%
19. List of your current and expected duties:	**20.** List duties requiring physical activities identified in question 19:
21. Employment status: ☐ Employee ☐ Self-Employed or Business Owner	**22.** If Self-Employed or Business Owner, (a) Percentage of Ownership: _____ (b) How many people are employed by your business/organization? _____ (c) Type of business: ☐ Sole Proprietor/1099 ☐ Partnership ☐ LLC ☐ S Corporation ☐ C Corporation
23. If Employee, what is your annual gross earned income (Total of Salary + Wages + Bonus + Commissions)? Current Year (annualized estimate): $_____ Prior Year $_____ If Self-Employed or a Business Owner, what is your net annual earned income (Total Salary + Wages + Bonus + Commission + Net Income of your business after Expenses)? Current Year (annualized estimate): $_____ Prior Year $ _____	

Select A Plan	
24. Monthly Benefit Amount:	
25. Included Rider:	☐ Own Occupation Extension Benefit Rider

26. Guaranteed Renewable to Age 67; Conditionally Renewable to Age 70; Graded Benefit for Sickness

Benefit Period ***(Select One)***		**Elimination Period** ***(Select One)***
☐	**10-Year**	☐ **90** ☐ **180** ☐ **365** ☐ **730** Days
☐	**7-Year**	☐ **90** ☐ **180** ☐ **365** ☐ **730** Days
☐	**5-Year**	☐ **30** ☐ **60** ☐ **90** ☐ **180** ☐ **365** ☐ **730** Days
☐	**3-Year**	☐ **30** ☐ **60** ☐ **90** ☐ **180** Days
☐	**2-Year**	☐ **30** ☐ **60** ☐ **90** ☐ **180** Days

Benefit Amount, Billing and Payment Information	
27. Premium Due*:	
28. Billing Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual	
*The Premium Due includes the applicable modal amount of the $50 Annual Policy Fee.	
29. Is the Applicant the Payor? ☐ Yes ☐ No	
If No, name of Payor as shown on bank account:	
Payor address:	

Other Disability Income Insurance Information	
30. Do you have disability insurance coverage with this Company or any other insurance company?	☐ Yes ☐ No
Do you intend to replace or change this existing disability insurance coverage?	☐ Yes ☐ No
Is this existing disability insurance coverage Individual or Group Long Term Disability?	☐ Individual ☐ Group
What is the total Monthly Benefit Amount of this existing disability insurance coverage?	$_____ per month ☐ Unknown

Personal Information	
31. Current height: _____ feet _____ inches Current weight: _____ pounds	
32. Are you a citizen (or hold a green card) and a resident of the United States of America?	☐ Yes ☐ No
33. Excluding marijuana, in the past 10 years have you ever used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit-forming drugs, except as prescribed by a member of the medical profession?	☐ Yes ☐ No
34. Has your driver's license been suspended, modified, limited or otherwise revoked in the past 2 years or have you ever been convicted of driving while impaired, intoxicated or under the influence? Driver's License Number: _____ Driver's License State of Issue: _____	☐ Yes ☐ No
35. In the past 10 years, have you ever plead guilty to or been convicted of a felony or misdemeanor?	☐ Yes ☐ No
36. Have you been paid any type of disability benefit in the past 5 years?	☐ Yes ☐ No
37. Have you had an insurance carrier ever decline, modify or rate a life, disability or health insurance policy?	☐ Yes ☐ No

Personal Health History

Primary care physician name:		Phone #:	
Address	City	State	Zip
Date and reason for last consultation with primary physician?			

38. Are you presently using any medications prescribed by a member of the medical profession?	☐ Yes ☐ No
39. In the past 12 months, have you or are you currently using marijuana in any form?	☐ Yes ☐ No
40. In the past 12 months, have you been treated, examined or advised by a member of the medical profession in a doctor's office or hospital or medical facility about your health?	☐ Yes ☐ No
41. In the past 5 years, have you had surgery performed, received a treatment or were prescribed by a member of the medical profession any diagnostic tests, including electrocardiogram (EKG) or X-ray, except for Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No
42. In the past 12 months, have you used any tobacco or nicotine products? Tobacco or nicotine products include cigarettes, chewing tobacco, smokeless tobacco, cigars, nicotine gum, patch, vaping, or electronic cigarettes.	☐ Yes ☐ No
43. In the past 12 months, have you sought medical treatment for alcohol misuse or dependence?	☐ Yes ☐ No
44. Are you currently pregnant? (Female Applicants Only) If yes, when is your due date?	☐ Yes ☐ No
45. In the past 5 years, have you been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No
46. In the past 12 months, have you been in a doctor's office, a hospital or an in-patient or out-patient medical facility for any medical or surgical advice, treatment or procedure, or been diagnosed by a member of the medical profession for any disease or disorder not listed in this Application?	☐ Yes ☐ No
47. In the past 10 years, have you been treated, examined or advised by a member of the medical profession for any physical impairment or deformity?	☐ Yes ☐ No
48. In the past 10 years, have you been treated, examined or diagnosed by a member of the medical profession for the following conditions: high blood pressure, diabetes, cancer, arthritis, asthma, emphysema, or emotional, nervous or mental disorder, disease or disorder of the eyes, ears or speech, disease or disorder of the heart, back pain or musculoskeletal disorders, or stroke?	☐ Yes ☐ No
49. In the past 5 years**,** have you been treated, examined or advised by a member of the medical profession for the following conditions:	
a. Fainting or dizziness ☐ Yes ☐ No **b.** Blackout	☐ Yes ☐ No

Activities and Travels

50. In the next 12 months, are you planning on traveling outside of the US for more than 10 days?	☐ Yes ☐ No
51. In the next 12 months, will you be participating in any of these activities more than once a year: flying as a licensed or unlicensed pilot, a stunt flyer, or flying as a pilot or passenger in an experimental, test or unlicensed aircraft?	☐ Yes ☐ No
52. In the next 12 months will you be taking part in skydiving, hang-gliding, parachuting, underwater diving, motocross, heliskiing, motorcycle or motor vehicle racing, rock climbing, flying any type of aircraft, bungee jumping, boxing, or professional or semi-professional sports?	☐ Yes ☐ No

Additional Information

If you answered "Yes" to questions #38-#52, please provide an explanation for each corresponding question number with: specific medical condition/diagnosis, date of diagnosis, type of treatment or surgery, dates of each, last treatment date, name and address of physicians consulted for each. If you need additional space, please use the Health History Continuation Form.

Question Number	**Diagnosis Date**	**Specific Condition and Diagnosis**
	Type of Treatment & Medications	**Surgeries and Dates**
	Last Treatment and Dates	**Physician Consulted (Name, Address, Phone Number)**

Question Number	Diagnosis Date	Specific Condition and Diagnosis
	Type of Treatment & Medications	Surgeries and Dates
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Question Number	Diagnosis Date	Specific Condition and Diagnosis
	Type of Treatment & Medications	Surgeries and Dates
	Last Treatment and Dates	Physician Consulted (Name, Address, Phone Number)}

Notice and Acknowledgement

I understand and agree that, under the terms of the insurance applied for, any indemnity for loss of time will not commence until after the elimination period selected on the second page of the application for any period of disability for accident, sickness, and/or nervous or mental disorders, and not before.

I have read the foregoing answers and state that they are full, complete and true to the best of my knowledge and belief as of the date I signed this Application 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. I understand any material misstatements or omissions made by me in this form may be used as a basis for rescinding my coverage. This means all claims will be denied and the Company's liability will be limited to a full refund of premiums less any claims previously paid. I understand and agree that no insurance coverage will be in effect until the Company issues a policy and receives payment of the full initial premium according to the premium mode selected in this Application. No producer can waive or change any receipt or policy provision or agree to issue a policy.

I have received and read a copy of the Pre-Notice, which describes how information is obtained and used by the Fidelity Security Life Insurance Company. I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, LLC (MIB), IntelliScript, ScriptCheck, Lexis/Nexis or other organization or institution that has any records or knowledge of me or my physical or mental health, including significant history, findings, diagnoses and treatment, including diagnosis and treatment of HIV/AIDS or sexually transmitted diseases, 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 the Fidelity Security Life Insurance Company, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my Application 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 signed copy of this authorization.

I agree to receive all documents and correspondence electronically and that I can access the internet, mobile phone or the email address provided. I understand that I may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company {or Administrator} by mail, email, or telephone. ☐ Yes ☐ No

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Electronic Signature

I have: (a) read and understand this Application; (b) read and approved the answers as recorded in this Application; (c) acknowledged that I have elected to apply for this insurance coverage electronically. I understand that part of the electronic Application process requires me to submit a "signed" Application, and that my "signature" on this Application will be electronic. I acknowledge and understand that my electronic "signature" is binding to the same extent as my written signature. I am providing electronic consent to process my Application by typing my name and date below.

Applicant's Signature Date Signed

Signed at (City, State) _____

AGENT INFORMATION

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

Will this coverage replace or change any of the coverages listed above? ☐ Yes ☐ No

Agent Signature ► _____ Agent ID No. _____

Agent Name (Please Print) _____ Telephone No _____

Address: _____

GENERAL FRAUD NOTICE: NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FRAUD NOTICE: For the states of AL, AZ, AR, CO, DE, DC, FL, GA, IN, KS, KY, LA, MD, ME, NC, NE, NH, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA and WV, please refer to the following fraud notices:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

Arizona: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: 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.

Georgia, Oregon, Vermont: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Nebraska: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false, incomplete or misleading information is guilty of insurance fraud.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

North Carolina: Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

MIB PRE- NOTICE

MIB 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, LLC., 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. 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 1022

FAIR CREDIT REPORTING ACT NOTICE

With regard to your application, We may request a consumer report or an investigative consumer report. These reports contain information about your character, general reputation, mode of living and health. No adverse underwriting decision will be made based on your sexual orientation. The information may have been obtained through interviews with you, your neighbors, friends and others who know you. Upon request, We will give you the name and address of the consumer reporting agency so that you may request a copy of the report.

93-33631 Rev 0316

FIDELITY SECURITY LIFE INSURANCE COMPANY®
INDIVIDUAL HEALTH HISTORY CONTINUATION FORM

Full Name of Applicant	
Residence Address	
City/State/Zip	Phone No. ( )

Please provide an explanation for question numbers #38-#52 with details (if additional space required, please use an additional sheet of paper signed and dated)

Question Number { }	**Diagnosis Date**	**Specific Condition and Diagnosis**
	Type of Treatment & Medications	**Surgeries and Dates**
	Last Treatment and Dates	**Physician Consulted (Name, Address, Phone Number)**
Question Number { }	**Diagnosis Date**	**Specific Condition and Diagnosis**
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Question Number { }	Diagnosis Date	Specific Condition and Diagnosis
	Type of Treatment & Medications	Surgeries and Dates
	Last Treatment and Dates	Physician Consulted (Name, Address, Phone Number)

I understand that this Health History Continuation Form will be made a part of the application for Disability Insurance.

I have read the foregoing answers and state that they are full, complete and true as of the date I signed the application and this Health History Continuation Form, and may be relied upon as the basis for any contract, which may be issued on account of the Application. These statements are to be considered representations and not warranties. I understand any material misstatements or omissions made by me in this form may be used as a basis for rescinding my coverage. This means all claims will be denied and the Company's liability will be limited to a full refund of premiums less any claims previously paid.

I understand and agree that no insurance coverage will be in effect until the Company issues a policy and receives payment of the full initial premium according to the premium mode selected in this Application. No producer can waive or change any receipt or policy provision or agree to issue a policy.

I have received and read a copy of the Pre-Notice, which describes how information is obtained and used by the Fidelity Security Life Insurance Company. I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, LLC (MIB), IntelliScript, ScriptCheck, Lexis/Nexis or other organization or institution that has any records or knowledge of me or my physical or mental health, including significant history, findings, diagnoses and treatment, including diagnosis and treatment of HIV/AIDS or sexually transmitted diseases, 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 the Fidelity Security Life Insurance Company, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my Application 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 signed copy of this authorization.

I agree to receive all documents and correspondence electronically and that I can access the internet, mobile phone or the email address provided. I understand that I may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company {or Administrator} by mail, email, or telephone. ☐Yes ☐No

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

► _____ Date: _____

Signature of Applicant

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, 1110 Brickell Avenue, Ste. 515 , 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 Risk Insurance and Reinsurance Solutions 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

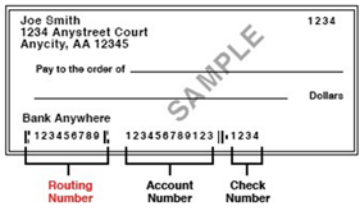
Name on Account: _____

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 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.