

**FIDELITY SECURITY LIFE INSURANCE COMPANY
APPLICATION FOR GROUP DISABILITY INSURANCE**

1. Full Name of Proposed Insured				
2. Home Telephone No. ()			3. Social Security No. \ \	
4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Marital Status	6. Height _____ ft. _____ in.	7. Weight _____ lbs.	8. Date of Birth
9. Birthplace	10. Age	11. Send Notice to: <input type="checkbox"/> Residence <input type="checkbox"/> Business		
12. Residence Address				
City/State/Zip			Phone No. ()	
13. Business Address				
City/State/Zip			Phone No. ()	
14. Name of Employer			15. Occupation (Job Title)	
16. Duties			17. Earned Annual Income _____	
17a. Beneficiary name (For Executive Platinum and Silver Only)			Relationship to Insured	

SELECT A PLAN

18. Plan of Insurance:

Executive Platinum (Graded Benefit Plan - Benefit Period: 5-Year Accident/Sickness)
Elimination Period (Select One): 60 90 120 180 365 Days Accident/Sickness

Executive Silver (Graded Benefit Plan - Benefit Period: 2-Year Accident/ Sickness)
Elimination Period (Select One): 30 60 90 180 Days Accident/Sickness

Executive Blue (Occupational Class _____ - Benefit Period: 2-Year Accident/Sickness)
Elimination Period (Select One): 30 60 Days Accident/Sickness

SELECT OPTIONS DESIRED FOR ("EXECUTIVE PLATINUM" AND "EXECUTIVE SILVER" ONLY)

19. Optional Riders

"A" - Partial Disability Rider: 50% of Basic Monthly Benefit, Up to 6 Months

"B" - Hospital Indemnity Rider: First Day Hospital, Up to 365 Days. Daily Benefit: \$25 \$50 \$75 \$100

"C" - Own Occupation Rider: Extends Definition to 5 Years (For Executive Platinum Only)

"D" - Home Health Care Rider: Maximum Benefit Up to 2 Years. \$50/Day \$100/Day

Beneficiary Name _____ Relationship to Insured _____

BENEFIT AMOUNT AND PREMIUM

20. Disability Income: \$ _____	Monthly Benefit	Annual Premium \$ _____
21. Optional Riders:	"A"	Annual Premium \$ _____
	"B" \$ _____ Per Day	Annual Premium \$ _____
	"C"	Annual Premium \$ _____
	"D" \$ _____ Per Day	Annual Premium \$ _____

22. Premiums:
 Total Annual Premium: \$ _____ Total Mode Premium: \$ _____ Amount Paid with Application: \$ _____
 Mode Annual Semiannual (.52) Quarterly (.265) Monthly (.091) List Bill

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. which operates an information exchange on behalf of insurance companies which are members of MIB, LLC. 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 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, LLC (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, LLC. 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 30 months 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 approved 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, LLC. (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:

- o Personal information and data about me;
- o Medical information, records and data about me, including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
- o 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;
- o 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
- o 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.

By signing below, I acknowledge my understanding that: 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.

- 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.**

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, 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 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

A sample check from Joe Smith, 1234 Anystreet Court, Anycity, AA 12345. The check is payable to the order of _____ Dollars. The bank is Bank Anywhere. The routing number is 123456789, the account number is 123456789123, and the check number is 1234. A large 'SAMPLE' watermark is overlaid on the check.

Routing Number Account Number Check Number

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.