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

1. Full Name of Proposed Insured				
2. Home Telephone No	D. ( )		3. Social Security No.	\ \
<b>4.</b> Sex ☐ Male ☐ Female	5. Marital Status	6. Height ft. in.	7. Weight lbs.	8. Date of Birth
9. Birthplace	<b>10.</b> Age	11. Send Notice to:	Residence	Business
12. Residence Address	5			
City/State/Zip			Phone No. ( )	
13. Business Address				
City/State/Zip			Phone No. ( )	
14. Name of Employer			15. Occupation (Job Ti	tle)
16. Duties			17. Earned Annual Inco	ome
17a. Beneficiary name	(For Executive Platinum	and Silver Only)	Relationship to Insured	
SELECT A PLAN				
<b>18.</b> 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			/s Accident/Sickness	
☐ Executive Silver	☐ Executive Silver (Graded Benefit Plan - Benefit Period: 2-Year Accident/Sickness)  Elimination Period (Select One): ☐ 30 ☐ 60 ☐ 90 ☐ 180 Days Accident/Sickness			ent/Sickness
☐ Executive Blue	☐ Executive Blue (Occupational Class Benefit Period: 2-Year Accident/Sickness)  Elimination Period (Select One): ☐ 30 ☐ 60 Days Accident/Sickness			s)
SELECT OPTIONS DESIR	ED FOR ("EXECUTIVE PLAT	TINLIM" AND "EXECUTIVES	SILVER" ONLY)	
<ol><li>Optional Riders</li></ol>				
☐ "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				
	emnity Rider: First Day Ho: ation Rider: Extends Definit			□\$75 □\$100
	h Care Rider: Maximum Be			
Beneficiary Name Relationship to Insured				
BENEFIT AMOUNT AND P				
20. Disability Income: \$_		onthly Benefit	Annual Premiu	•
21. Optional Riders:	"A		Annual Premiu	
	"B	" \$ Per Day		m \$ m \$
		" \$ Per Day	Annual Premiul	
		-		
22. Premiums:	<b>—</b>			P (1 A
Total Annual Premiur			Amount Paid with Ap	plication: \$
Mode ∐ Annual 〔	」 Semiannual (.52)  □	Quarterly (.265)	nthly (.091)	

Underwritten by: Fidelity Security Life Insurance Company, Kansas City MO Marketed by: IMI/Risk Insurance and Reinsurance Solutions

Policy Form No. M-4004 A-00677CA PLEASE COMPLETE OTHER SIDE

08/04

HE	ALTH HISTORY						
		mployed outside the home	e for a minimum of 30	0 hours per	week and have been so for		
	the past year? If no, please explainNo				No 🗌		
24.	24. Have you received medical advice or been confined to a hospital, nursing home or similar establishment						
						Yes 🗌	No 🗆
25.	-	n treated for or ever had a	-	, , -	•		
					rder, or disease or disorder		_
						Yes □	No 🗀
26.		n diagnosed by, or receive					
						Yes ⊔	No 📙
27.					er sought help or treatment		$\Box$
						Yes □	No 📙
28.					al advice or treatment, had		$\Box$
					er?	Yes ∟	No 📙
29.		de an application for disab				V □	NI- 🖂
20					, dates and reason.)		No □ No □
							No $\square$
					?		No 🗆
							No 🗆
		swers to 23-33. Include d				1 65 🗀	NO L
Giv	re details of yes all	swers to 25-55. Include a	iagnoses, dates, prij	ysicians and	i addresses.		
Dis	sability income insur	ance in force: (if none, so	state). Is replacem	nent intended	d?	Yes	No 🗌
	asimi, mosmo mosmo	(, 00		se explain:_			
(	Company Name	Mo. Benefit			e Replaced or Changed?	Policy Nu	ımber
	, ,				☐ Yes ☐ No	ĺ	
					☐ Yes ☐ No		
If th	he Executive Blue P	lan of Insurance applied for	or cannot be issued y	within the U		L ₽	
	If the Executive Blue Plan of Insurance applied for cannot be issued within the Underwriting Guidelines, please issue the Executive Silver Graded Benefit Disability Income Plan of Insurance						No 🗆
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#### 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	

U-00003CA Rev 10/16

### 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, 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: <u>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.</u>

- 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.

	determine the instructing of other running 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:	



## FIDELITY SECURITY LIFE INSURANCE COMPANY®

3130 Broadway Kansas City, Missouri 64111-2406 Phone 800-648-8624 A STOCK COMPANY (Herein Called "the Company")

### NOTICE AT COLLECTION FOR CALIFORNIA RESIDENTS

Fidelity Security Life Insurance Company® ("FSL", "we", "us" or "our") is committed to being transparent about how we use, collect and protect personal information. This Notice at the Time of Collection ("CCPA Notice") describes the categories and common examples of personal information collected from California residents ("you", "your") and the purposes for which the categories of personal information will be used. We adopt this Notice to comply with the California Consumer Privacy Act of 2018 (CCPA). This CCPA Notice does not apply to consumers' personal information exempted from the CCPA, such as personal information collected pursuant to (i) the federal Gramm-Leach-Bliley Act and its implementing regulations or the California Financial Information Privacy Act; or (ii) certain medical and health information covered by HIPAA.

We collect information that identifies, relates to, describes, is reasonably capable of being associated with, or could reasonably be linked, directly or indirectly, with a particular consumer or household ("personal information"). We may collect, and within the last twelve (12) months we may have collected, the following categories of personal information from the sources identified below for the business and commercial purposes indicated, and shared such categories of personal information with the specified categories of third parties.

### **What Information Does FSL Collect?**

FSL collects the following types of personal information from you as categorized by the CCPA:

CCPA Category of Personal Information	Examples
Personal Identifiers.	Examples include but are not limited to: a real name, alias,
	postal address, unique personal identifier, email address,
	social security number, driver's license number, or other
	similar identifiers.
Categories of personal information described in the	Examples include but are not limited to: a name, signature,
California Customer Records Statute (Cal. Civ. Code	social security number, address, telephone number, driver's
1798.80).	license or state identification card number, insurance policy
	number, education, employment information including
	history, bank account number, credit card number, debit card
	number, or any other financial information, medical
	information, or health insurance information.
Internet or other electronic network activity information	Examples include but are not limited to: browsing history,
	search history, and information regarding a consumer's
	interaction with an Internet Web site, application, or
	advertisement.
Characteristics of protected classes under California or	Examples include but are not limited to: age, gender,
federal law.	pregnancy, citizenship, familial status, medical condition,
	physical or mental disability, veteran or military status.
Sensory Data	Examples include but are not limited to: voice recordings of
	telephone calls with us, audio, voice, electronic, or similar
	information.

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### Business Purposes for which the Categories of Personal Information is Used

We may use your personal information for performance of our services, and for other purposes as permitted by law. Some examples include:

- Marketing and providing insurance to California residents;
- Determining your eligibility for a quote;
- Calculating your premium;
- Administering claims;
- Answering questions and providing notifications;
- Supporting day-to-day business operations and insurance related functions;
- Detecting security incidents, protecting against fraudulent or illegal activity, and to comply with regulatory and law enforcement authorities:
- Confirming your identity and servicing your policy;
- Providing customer and technical support;
- Enhancing your customer experience and improving our products and services;
- Creating, maintaining, customizing and securing accounts;
- Undertaking internal research for technological development;
- Developing and offering new products and services;
- Marketing products and services with strategic partners;
- Exercising and defending our legal rights and positions;
- Managing risk and securing our systems, assets, infrastructure, and premises;
- Responding to law enforcement requests and as required by applicable law, court order, or governmental regulations;
- To fulfill FSL's contractual obligations;
- To help ensure the safety and security of FSL's staff, assets, and resources, which may include, but is not limited to, physical and virtual access controls and access rights management; supervisory controls and other monitoring and reviews, as allowed by law; and emergency and business continuity management; and
- As otherwise required by federal or state law.

We will not collect additional categories of personal information or use the personal information we collected for materially different, unrelated or incompatible purposes without providing you notice.

### **Additional Information**

FSL does not sell consumers' personal information triggering opt out requirements under CCPA.

For additional information on the Personal Information we collect and your rights under the CCPA, please review our California Privacy Notice found on our website at <a href="https://www.fslins.com">www.fslins.com</a>.

If you have questions about this Notice, please contact us at:

Phone: 800-648-8624

Email: CCPA-Request@fslins.com

Address: Fidelity Security Life Insurance Company

Attn: Customer Service Department

3130 Broadway

Kansas City, MO 64111

# 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  $(1^{st}, 2^{nd} \text{ or } 3^{rd} \text{ of the month.}).$ OR please draft initial premium from my checking account \_\_\_\_ Monthly \_\_\_Quarterly \_\_\_Semiannual \_\_\_Annual Draft Date 1<sup>st</sup> 15<sup>th</sup> 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: \_\_\_\_\_Policy #: \_\_\_\_\_ Address: State: Zip: \_\_\_\_\_ Mobile Phone #: Email address for notifications: Home Phone #: **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 |: Pay to the order of \_ Bank Account number: For accurate processing, please attach a voided check

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.

Date:

Signature of Bank Account Holder: