FIDELITY SECURITY LIFE INSURANCE COMPANY OF NEW YORK — SDN-1
APPLICATION FOR INDIVIDUAL DISABILITY INSURANCE

GENERAL INFORMATION

1. Full Name of Proposed Insured

2. Sex ☐ Male ☐ Female	**3.** Marital Status	**4.** Height _____ ft. _____ in.	**5.** Weight _____ lbs.

6. Date of Birth	**7.** Birthplace	**8.** Age	**9.** Social Security No. \ \

10. E-Mail Address

11. Send Notice to: ☐ Residence ☐ 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

18. What % of your duties include physical activity, such as climbing, crouching, lifting, etc.? _____ %

19. List duties requiring physical activities identified in question 18.

20. Beneficiary Name — Relationship to Insured

SELECT A PLAN

21. ☐ **Platinum eZ-Select**

Guaranteed Renewable to Age 65; Conditionally Renewable to Age 70; Graded Benefit for Sickness

Benefit Period *(Select One)*	Elimination Period *(Select One)*
☐ **5-Year**	☐**90** ☐**120** ☐**180** Days
☐ **3-Year**	☐**60** ☐**90** ☐**120** ☐**180** Days
☐ **2-Year**	☐**30** ☐**60** ☐**90** ☐**120** ☐**180** Days
☐ **1-Year**	☐**30** ☐**60** ☐**90** Days

BENEFIT AMOUNT AND PREMIUM

22. Disability Income: Monthly Benefit $_____ Annual Premium $_____

Total Mode Premium: $_____ Amount Paid with Application: $_____

Mode: ☐ Annual (1.00) ☐ Semiannual (.52) ☐ Quarterly (.265) ☐ Monthly (.091)

HEALTH HISTORY

23. Are you gainfully employed outside the home for a minimum of 30 hours per week and have been so for the past year? If no, please explain_____ ..... Yes ☐ No ☐

24. Have you received medical advice or been confined to a hospital, nursing home or similar establishment or been disabled within the last 12 months? ..... Yes ☐ No ☐

25. To the best of your knowledge and belief, have you ever been treated for or ever had any known indication of 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, or stroke? ..... Yes ☐ No ☐

26. To the best of your knowledge and belief, have you ever been diagnosed by, or received treatment from a licensed physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immune disorder (do not consider any previous HIV test results when answering this question)? ..... Yes ☐ No ☐

27. Have you ever used barbiturates, narcotics, excitants or hallucinogens, or ever sought help or treatment for their use or alcohol use? ..... Yes ☐ No ☐

28. Other than above, to the best of your knowledge and belief, have you, within the past five years, had medical or surgical advice or treatment, had a physical examination, or been under observation for any disease or disorder? ..... Yes ☐ No ☐

29. Have you ever made an application for disability, health or life insurance which has been declined, modified or rated up? (If yes, give names of organization, kinds of insurance, dates and reason.) ..... Yes ☐ No ☐

30. Do you have a physical impairment or deformity? ..... Yes ☐ No ☐

HEALTH HISTORY (CONTINUED)

31. Have you ever made claim or received benefits for disability from any source? ..... Yes ☐ No ☐
32. Are you presently taking any prescribed medication? ..... Yes ☐ No ☐
33. Have you used tobacco products, in any form, in the past 12 months?..... Yes ☐ No ☐

Give details of "No" answer to question 23 and "Yes" answers to questions 24-33 on the "Health History Continuation Form". The "Health History Continuation Form" will be considered to be part of this application.

34. Is this coverage intended to replace or change any existing disability income coverage? ..... Yes ☐ No ☐
35. List all disability income coverage in force or applied for, including individual disability income policies, sick pay plans, salary continuation plans, group long and short-term disability coverage and credit disability insurance:
(If none, check here ☐).

Company or Source	Monthly Benefit	Benefit Period	Elimination Period	Policy Number	Please Check if being Replaced or Changed*	Coordinates with Social Security?	Who Pays?
					☐	☐Yes ☐ No	
					☐	☐Yes ☐ No	
					☐	☐Yes ☐ No	
*Please explain:							

If the Plan of Insurance applied for cannot be issued within the Underwriting Guidelines, would you like this application to be considered for other Disability Income plans available?. ..... Yes ☐ No ☐

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 _____ day of 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 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 have received and read a copy of the Pre-Notice which describes how information is obtained and used by Fidelity Security Life Insurance Company of New York (FSLNY).

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 physical or mental health, including significant history, findings, diagnosis 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 FSLNY, 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 FSLNY.. FSLNY 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 FSLNY, 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 twenty-four 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 of New York, Administrative Office, P.O. Box 418131, Kansas City, MO 64111-8131, 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, FSLNY 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 that I will receive a signed copy of this authorization.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Dated at _____ this _____ day of _____, 20_____

Witnessed by ► _____ ► _____

Signature of Licensed Agent or Witness — Signature of Proposed Insured

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:_____

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

Received from _____ the sum of $_____ for the full first premium and benefit amount specified in the application for disability income insurance with Fidelity Security Life Insurance Company of New York (FSLNY) which bears the same date as this receipt. The insurance under the Policy for which application is made will be effective on the date the underwriting is complete and the application is approved by FSLNY. If the Proposed Insured is not insurable and acceptable or the amount of insurance does not meet FSLNY's underwriting guidelines, FSLNY 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 _____

FIDELITY SECURITY LIFE INSURANCE COMPANY OF NEW YORK
INDIVIDUAL HEALTH HISTORY CONTINUATION FORM

SDN-1

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

Details for "No" answer to question 23 and "Yes" answers to questions 24-33	
Question No.	**Details (Questions 24-33 include diagnoses, dates, physicians and addresses)**

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 this application. These statements are to be considered representations and not warranties..

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 of New York (FSLNY).

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 physical or mental health, including significant history, findings, diagnosis 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 FSLNY, 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 FSLNY.. FSLNY 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 FSLNY, 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 twenty-four 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 of New York, Administrative Office, P.O. Box 418131, Kansas City, MO 64111-8131, 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, FSLNY 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 that I will receive a signed copy of this authorization.

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

► _____ Date: _____

Signature of Proposed Insured

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 of New York (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.

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 of New York.

- 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 of New York, Attn: HIPAA Privacy Law Compliance Officer, at Administrative Office: 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: _____

PRE-NOTICE

Although your application is our main source of information, we at Fidelity Security Life Insurance Company of New York 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 of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., 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 of New York 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 0414

FIDELITY SECURITY LIFE INSURANCE COMPANY OF NEW YORK
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 of New York. 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 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 of New York, 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 of New York.

Fidelity Security Life Insurance Company of New York 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 of New York 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 of New York 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 of New York 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 _____

New York Insurance Agent
Regulation 194 Commission Disclosure

This notification is intended to comply with disclosure aspects of New York Regulation 194 (insurance commission disclosure) effective January 1, 2011.

As an insurance consumer, you are hereby notified that I am a contracted life insurance agent of _____ insurance company. As a licensed Life insurance agent in the state of New York, I am licensed to talk with consumers about the benefits, terms and conditions of insurance contracts or policies; to offer advice concerning the substantive benefits of particular insurance contracts or policies; sell various insurance products; and to obtain insurance for people who want to purchase insurance. My role as an insurance agent in any particular transaction typically involves one or more of these activities.

My compensation for these activities is primarily a commission which is built into the cost for the insurance products I sell and is paid to me directly from the insurance company. Producer compensation is limited by New York State law.

My compensation may vary depending upon a number of factors including but not limited to; the insurance product, insurance company, and my volume of business with the company.

All producers are prohibited by New York State law from rebating commissions.

As an insurance consumer, you may obtain additional information about my expected compensation in whole or in part by making a written request at the time of and following my sales presentation or within 30 days after the policy or contract has been issued by the insurance company.

I have read the above disclosure and understand that my agent is primarily compensated directly by commission from the sale of insurance directly from the Company

_____ Proposed Insured/Owner _____ Date

Fidelity Security Life Insurance Company of New York

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) 421-4185* or by mail: *Risk Insurance, 1208 W Newport Center Drive, Suite 202, Deerfield Beach, FL 33442*

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)

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 of New York (FSLNY) 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

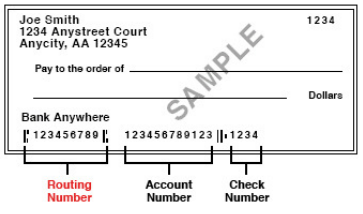
Name on Account: _____

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 of New York 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.

Fidelity Security Life Insurance Company of New York

Automatic (ACH) premium 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) 421-4185* or by mail: *Risk Insurance, 1208 W Newport Center Drive, Suite 202, Deerfield Beach, FL 33442*

Current Premium notice should be paid by check: *Please pay your current Premium Notice by check as usual 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)

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 continue to 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 of New York (FSLNY) 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

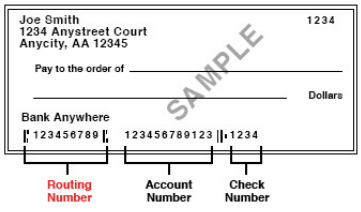
Name on Account: _____

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 of New York 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.