FIDELITY SECURITY LIFE INSURANCE COMPANY APPLICATION FOR GROUP DISABILITY INSURANCE

1. Sex	2. Home Telephone No. ()		3. Social Security No.		
	5. Marital Status	6. Height	7. Weight	8. Date of Birth	
☐ Male ☐ Female ☐ Birthplace	10. Age	fti 11. Send Notice to	n. <u> </u>	Business	
. Dirtiipiace	10. Age	11. Send Notice to	o. Nesidence		
2. Residence Address					
City/State/Zip			Phone No. ()		
3. Business Address					
City/State/Zip			Phone No. ()		
14. Name of Employer			15. Occupation (Job	Title)	
16. Duties			17. Earned Annual In	ncome	
17a. Beneficiary name ((For Executive Plating	um and Silver Only)	Relationship to Insure	ed	
•	`		·		
	(Graded Benefit Plan - Elimination Period (Se		ar Accident/Sickness) ☐120 ☐180 ☐365 Days	s Accident/Sickness	
18. Plan of Insurance: Executive Platinum Executive Silver Executive Blue	Elimination Period (Section of Control of Co	lect One):	□ 120 □ 180 □ 365 Days ar Accident/ Sickness) □ 90 □ 180 Days Accident od: 2-Year Accident/Sickn	nt/Sickness	
8. Plan of Insurance: Executive Platinum Executive Silver (Elimination Period (Secondary Control of Secondary	Benefit Period: 2-Ye lect One : 30 60 60	□ 120 □ 180 □ 365 Days ar Accident/ Sickness) □ 90 □ 180 Days Accider od: 2-Year Accident/Sickn Days Accident/Sickness	nt/Sickness	
Executive Platinum	Elimination Period (Secondary Relation Period (Secondary Relation Period (Secondary Relation Period (Secondary Relation Period (Secondary Rider: 50% of Basis Manity Rider: First Day Hitton Rider: Extends Define (Secondary Rider: Extends Define Rider: Extends Define (Secondary Rider: Extends Define Rider: Ex	Benefit Period: 2-Ye lect One : 30 60 60	□ 120 □ 180 □ 365 Days ar Accident/ Sickness) □ 90 □ 180 Days Accident ad: 2-Year Accident/Sickness CUTIVE SILVER" ONLY) 6 Months □ Daily Benefit: □ \$25 □ \$56 Executive Platinum Only)	nt/Sickness ness) 0	
8. Plan of Insurance: Executive Platinum Executive Silver Executive Blue ELECT OPTIONS DESIR 9. Optional Riders "A" - Partial Disabil "B" - Hospital Inder "C" - Own Occupat "C" - Home Health Beneficiary N	Elimination Period (Secondary Control of Secondary Control of Care Rider: Maximum Control of Secondary Control of	Benefit Period: 2-Ye lect One): 30 60	□ 120 □ 180 □ 365 Days ar Accident/ Sickness) □ 90 □ 180 Days Accident ad: 2-Year Accident/Sickness CUTIVE SILVER" ONLY) 6 Months □ Daily Benefit: □ \$25 □ \$56 Executive Platinum Only)	nt/Sickness ness) 0	
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Marketed by: Risk Insurance and Reinsurance Solutions, Inc.

08/04

HEALTH HISTORY								
22 A			f 00 h					
23. Are you gainfully emthe past year? If no		ome for a minim	um oi 30 no	ours per v	veek ar	id have been	Yes	No 🗌
24. Have you received r		n confined to a	hospital, nu	rsina hon	ne or si	milar establish		110 🗀
or been disabled wit	thin the last 12 months	s?					Yes 🗀	No 🗌
25. Have you ever been								
	hma, emphysema, or							No 🗆
26. Have you ever been	speech?						Yes _	No 📙
	Syndrome (AIDS), All						er?Yes 🗀	No □
27. Have you ever used	• • • • • • • • • • • • • • • • • • • •							
for their use or alcoh	nol use?						Yes 🗌	No 🗌
28. Other than above, h		•		_			·	—
	ion, or been under ob		-					No 📙
29. Have you ever made	e an application for dis ? (If yes, give names							No 🗆
30. Do you have a phys	` ' ' '	•	•			,		No 🗆
31. Have you ever made								_
32. Are you presently ta								
33. Have you used any	tobacco products in the	ne past 12 mon	ths?					
Give details of "Yes" and	swers to 23-33. Includ	e diagnoses, da	ates, physic	ians and	addres	ses.		
-								
Disability income insura	nce in force: (if none,	so state). Is re	placement	intended?	?		Yes 🗌	No 🗌
			es please ex					
Company Name	Mo. Benefit	Benefit Pe	riod T	o Be Rep		or Changed?	Policy Nu	mber
					Yes Yes	☐ No ☐ No		
If the Executive Blue Pla	I an of Insurance applie	l d for cannot be	issued with	in the Un			 s_please	
issue the Executive Silve								No 🗌
I understand and ac United Associations of	knowledge the follow	ing: by applyin ance Trust Ti	g for this in: ne Master I	surance, l Policy for	I am als	so being acce	pted as a memb	er of the
receive a certificate as	evidence of my insura	nce under the	Trust Policy	. The Tru	ust is n	ot the Insuran	ice Company. T	he Trust
has no responsibility for	this insurance except	to hold the Pol	icy.	d for on	, in dom	with for loss of	f time will not on	
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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, 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 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

HIPAA AUTHORIZATION

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

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

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

Signature of Proposed Insured	Month/Day/Year		
Printed Name of Proposed Insured	_	Date of Birth	
City	 State		

U-00003 Rev 09/12

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

Received from
The sum of \$
For the full first premium specified in the application for insurance in the Fidelity Security Life Insurance Company which bears the same date as this receipt. The insurance under the Policy for which application is made will be effective on the date aproved by the Company. If the Proposed Insured is not insurable and acceptable, the Company will refund all premiums paid to date by the Proposed Insured. This receipt will be void if given for check or draft which is not honored on presentation.
Do not make check payable to agent or leave payee blank.
, 20
Agent

AUTHORIZATION TO COMPLY WITH HIPAA PRIVACY REQUIREMENTS

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

- Any medical practitioner or facility or related entity; any insurer; The Medical Information Bureau, Inc. (MIB); any employer; group policyholder; contract holder, or any benefit plan administrator to give Fidelity Security Life Insurance Company (the "Company"), or **Risk Insurance and Reinsurance Solutions, Inc.**, who is acting on behalf of the Company in this regard:
 - 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 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:	