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 ☐ Male ☐ Female	**5.** Marital Status	**6.** Height _____ ft. _____in.	**7**. Weight _____ lbs.	**8.** Date of Birth
9. Birthplace	**10.** Age	**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 _____	
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

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

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. Have you ever been treated for or ever had any known indication of (a) high blood pressure, diabetes, cancer, arthritis, asthma, emphysema, or emotional, nervous or mental disorder, or disease or disorder of the eyes, ears or speech? ☐ Yes ☐ No

26. 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? ☐ 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, 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

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 any tobacco products in the past 12 months? ☐ Yes ☐ No

Give details of "Yes" answers to 23-33. Include diagnoses, dates, physicians and addresses.

_____

_____

_____

Disability income insurance in force: (if none, so state). Is replacement intended? ☐ Yes ☐ No

If yes please explain:_____

Company Name	Mo. Benefit	Benefit Period	To Be Replaced or Changed?	Policy Number
			☐ Yes ☐ No	
			☐ Yes ☐ No	

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. **Yes** ☐ **No** ☐

I understand and acknowledge the following: by applying for this insurance, I am also being accepted as a member of the United Associations of America Group Insurance Trust. The Master Policy for this insurance is issued to the Trust. I will receive a certificate as evidence of my insurance under the Trust Policy. The Trust is not the Insurance Company. The Trust has no responsibility for this insurance except to hold the Policy.

I understand and agree that, under the terms of the insurance applied for, any indemnity for loss of time will not commence until after (a) with the _____ day of any period of disability for accident; (b) with the _____ day of any period of disability for sickness, 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 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 Insurance Company's liability will be limited to a full refund of premiums less any claims previously paid.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or the Medical Information Bureau, Inc. that has any records or knowledge of me or my health, or that of my family, to give to Fidelity Security Life Insurance Company, Risk Insurance and Reinsurance Solutions and/or its Reinsurers, any such information for their use to determine eligibility for insurance or benefits under an existing policy. 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 below.

I have read and received a copy of the Pre-Notice which described how information is obtained and used by Fidelity Security Life Insurance Company.

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

Dated at_____ this _____ day of _____, 20_____

Witnessed by **X**_____ **X**_____

Signature of Licensed Agent or Witness — Signature of Proposed Insured

Agent's Name (please print) I.D. No.
Address
City/State/Zip
Tel No. ( ) Fax No. ( )

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

_____

Agent Signature **X**_____

Agent No. _____

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

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:
  - 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.

- 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: _____