FIDELITY SECURITY LIFE INSURANCE COMPANY
APPLICATION FOR INDIVIDUAL DISABILITY INSURANCE

1. Full Name of Proposed Insured				
2. Social Security No. - -	3. Sex ☐ Male ☐ Female	4. Marital Status	5. Height _____ ft. _____in.	6. Weight _____ lbs.
7. Date of Birth	8. Birthplace	9. Age	10. Send Notice to: ☐ Residence ☐ Business	
11. Residence Address				
City/State/Zip			Home Telephone No. ( )	
12. Business Address				
City/State/Zip			Business Telephone No. ( )	
Email Address (optional)				}
13. Name of Employer			14. Occupation (Job Title)	
15. Duties			16. Earned Annual Income _____	
16a. Beneficiary name (For Graded Benefit Plans Only)			Relationship to Insured	

SELECT A PLAN

18. Plan of Insurance:

☐ **Executive Platinum Plan (SD-16 Graded Benefit Plan)**
Elimination Period: ☐ **60** ☐ **90** ☐ **120** ☐ **180** ☐ **365 Day Accident/Sickness**
Benefit Period: 5-Year Accident/5-Year Sickness

☐ **Executive Silver Plan (SD-17 Graded Benefit Plan)**
Elimination Period: ☐ **30** ☐ **60** ☐ **90** ☐ **180 Day Accident/Sickness**
Benefit Period: 2-Year Accident/2-Year Sickness

☐ **Executive Blue Plan (Non-Graded Benefit Plan)**
(SD-18 Classes AAA/AA)
(SD-19 Classes A/B)
Elimination Period: ☐ **30** ☐ **60 Day Accident/Sickness**
Benefit Period: 2-Year Accident/2-Year Sickness

Occupational Class _____

SELECT OPTIONS DESIRED (FOR GRADED BENEFIT PLANS 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 Graded Benefit Plan with 5 Year Benefit Only)
- ☐ "D" - Home Health Care Rider: Maximum Benefit Up to 2 Years. ☐ $50/Day ☐ $100/Day

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: $_____
Premium Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

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 advise 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, heart or liver disease or disorder, 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. If additional space is needed, please use a separate sheet of paper which is signed and dated.

_____

_____

_____

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 Non-graded Plan of Insurance applied for cannot be issued within the Underwriting Guidelines, please issue the Graded Benefit Disability Income Plan of Insurance with the 2 Year Benefit Period. .....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: (a) the _____ day of any period of disability for accident; (b) 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, 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, its authorized agent, Risk Insurance and Reinsurance Solutions, Inc., 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.

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
Telephone No. ( )

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

Agent Signature **X**_____

Agent No. _____

Conditional 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 _____

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 you or members of your family's insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02212; phone number (617)426-3660.

We or our reinsurer(s) may also release information in our file to other life insurance companies to whom you submit a claim. For a reasonable fee, we will provide you with information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. (California residents only, medical information will be disclosed directly to you or the medical professional you designate.) Should you wish to request a correction, amendment or deletion of any information in your file which you believe is inaccurate, please contact us and we will advise you of the necessary procedures.