FIDELITY SECURITY LIFE INSURANCE COMPANY
APPLICATION FOR GROUP DISABILITY INSURANCE

SD-32

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** ☐ **365** ☐ **730** Days
☐	**3-Year**	☐ **60** ☐ **90** ☐ **120** ☐ **180** ☐ **365** ☐ **730** Days
☐	**2-Year**	☐ **30** ☐ **60** ☐ **90** ☐ **120** ☐ **180** ☐ **365** ☐ **730** 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) ☐ List Bill

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 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. 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? (HIV test results need not be disclosed) ..... 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 ☐

HEALTH HISTORY (CONTINUED)

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 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 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 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 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 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., other organization or institution that has any records or knowledge of 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 Fidelity Security Life Insurance Company, plan administrators, business associates, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. Fidelity Security Life Insurance Company or its authorized representatives may release to the plan administrators, business associates, other insurance companies, MIB, Inc. or others whom I authorize in writing, information covered by this authorization.

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 hereby represent that I have reviewed the fraud warning notice (if applicable) included with this application for my state of residence.

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: _____

FRAUD WARNING NOTICE	
For residents of all states (except the following)	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Nebraska	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
Tennessee	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Virginia	Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

FIDELITY SECURITY LIFE INSURANCE COMPANY
HEALTH HISTORY CONTINUATION FORM

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 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 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., other organization or institution that has any records or knowledge of 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 Fidelity Security Life Insurance Company, plan administrators, business associates, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. Fidelity Security Life Insurance Company or its authorized representatives may release to the plan administrators, business associates, other insurance companies, MIB, Inc. or others whom I authorize in writing, information covered by this authorization.

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 hereby represent that I have reviewed the fraud warning notice (if applicable) included with the application.

► _____ Date: _____

Signature of Proposed Insured

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 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 _____

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: _____