# FIDELITY SECURITY LIFE INSURANCE COMPANY
# 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** ☐ **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 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 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? ..... 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 ☐

## HEALTH HISTORY (CONTINUED)

**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 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. (MIB), IntelliScript, or, other organization or institution that has any records or knowledge of 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 the 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 24 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 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 signed copy of this authorization.

**Any person who, with 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 be guilty of insurance fraud.**

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 replaced or change any of the coverage listed above? ☐ Yes ☐ No

Agent Signature ►_____ Agent ID No._____

Agent Name (Please Print)_____ Telephone No. (___)_____

Address:_____

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 _____

**FIDELITY SECURITY LIFE INSURANCE COMPANY**
**INDIVIDUAL HEALTH HISTORY CONTINUATION FORM**

| | |
|---|---|
| Full Name of Proposed Insured | |
| Residence Address | |
| City/State/Zip | Phone No.<br>( ) |

**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. (MIB), IntelliScript, or other organization or institution that has any records or knowledge of me or my {or my dependents} 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 24 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 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 signed copy of this authorization.

**Any person who with 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 be guilty of insurance fraud.**

► _____ 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 (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.
- 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.**

**REVOCATION:** You or your personal representative may cancel this authorization for future releases by submitting a written request to the Release of Information Unit at Risk Insurance 1111 Brickell Ave., #2600 Miami, FL 33131. Your cancellation will not affect information that was released prior to receipt of the written request.

**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: _____