Application for Life Insurance

Fidelity Life Association, A Legal Reserve Life Insurance Company

FIDELITYLIFE
Established 1896

PROPOSED INSURED

Full Legal Name of the Proposed Insured: _____ Gender: ☐ Male ☐ Female

Date of Birth:_____ Age: _____ Place of Birth: _____ Social Security Number: _____

Legal Residence Address: _____ Years _____

Best Time to Call (if needed): _____ ☐AM ☐PM Preferred #: (____) _____ Alternate #: (____)_____

Are you a United States citizen or do you have Permanent Resident Status (a Green Card)? ☐ Yes ☐ No

Driver's License Number: _____ State of Issue: _____

Occupation: _____ Years in this occupation: _____

Employer or Business Name: _____ Annual Income: $ _____

COVERAGE

Product: _____ Face Amount: $ _____

Level premium period: _____ years (if applicable).

☐ Dependent Child Rider: $ _____ ☐ Waiver of Premium on Total Disability

☐ Accidental Death Benefit: $ _____ ☐ Return of Premium/Cash Value(where applicable) Rider

Mode of Payment: _____ Billing Method: _____ Amount Paid With Application: $ _____

Not all Products or Riders are available in all States. Refer to Product Guide for details.

OTHER COVERAGE

Do you have any existing life insurance in force or is any application for life insurance, or reinstatement, now pending? ☐ Yes ☐ No

Name of Company:_____ Face Amount: $ _____ Year Issued: _____ To Be Replaced? ☐ Yes ☐ No

Name of Company:_____ Face Amount: $ _____ Year Issued: _____ To Be Replaced? ☐ Yes ☐ No

Name of Company:_____ Face Amount: $ _____ Year Issued: _____ To Be Replaced? ☐ Yes ☐ No

Name of Company:_____ Face Amount: $ _____ Year Issued: _____ To Be Replaced? ☐ Yes ☐ No

If this policy is issued, will any other existing life insurance or annuity be cancelled, terminated, lapsed or not renewed? ☐ Yes ☐ No

OWNER AND BENEFICIARY

Policyowner *(The Policyowner will be the Proposed Insured unless otherwise indicated)*

Name of Policyowner:	Relationship to Insured:	SSN/Tax ID:
_____	_____	_____

Billing Address: _____

Secondary Addressee *(Optional. This person will receive copies of your overdue premium and lapse notices)*

Name: _____ Mailing Address:_____

Beneficiary *(Complex beneficiary designations should be dealt with within the context of a Will)*

Primary:	Percent of Proceeds	Relationship to Insured:	SSN/Tax ID:
_____	_____	_____	_____
_____	_____	_____	_____
Contingent:	**Percent of Proceeds**	**Relationship to Insured:**	**SSN/Tax ID:**
_____	_____	_____	_____

If more space is needed attached a separate, signed and dated sheet of paper.

Name of Proposed Insured:

1. Do you have a regular physician? ☐ Yes ☐ No If **Yes**, give information below. If **No**, show the last physician seen.
   Name of physician: _____ Date last seen: _____
   Address: _____ Telephone: _____

2a. Your Height: _____ ft/in Your Weight: _____ lbs. 2b. Have you lost weight in the past year? ☐Yes _____ lbs. ☐ No

3. Have you, within the past 10 years, been treated by a licensed member of the medical profession for or been diagnosed as having:
   a. a heart attack (myocardial infarction), angina, irregular heart beat or abnormal heart rhythm (arrhythmia), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke, or transient ischemic attack (TIA or mini-stroke)? ☐ Yes ☐ No
   b. diabetes, high blood sugar, sugar in the urine, anemia, liver disease, kidney disease (other than kidney stones), Crohn's disease, ulcerative colitis, other intestinal disease or pancreatitis? ☐ Yes ☐ No
   c. internal cancer or tumor, melanoma, lymphoma, leukemia,? ☐ Yes ☐ No
   d. Alzheimer's disease (dementia) , memory loss, seizures, mental retardation (including Down's syndrome), Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson's disease, Amyotrophic Lateral Sclerosis (ALS), cerebral palsy or any form of muscular atrophy? ☐ Yes ☐ No
   e. sleep apnea, cystic fibrosis, emphysema or chronic obstructive lung disease (COLD), rheumatoid arthritis, paralysis, lupus or scleroderma? ☐ Yes ☐ No
   f. enlarged prostate or elevated prostate specific antigen (PSA) ☐ Yes ☐ No
   g. hypertension (high blood pressure), elevated cholesterol, or asthma? ☐ Yes ☐ No
   h. anxiety, depression, panic attacks, schizophrenia, anorexia or bulimia? ☐ Yes ☐ No

4. To the best of your knowledge and belief, have you or any person proposed for insurance tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No

5. Have you, within the past 12 months, received disability benefits of any kind or been disabled for more than 30 days? ☐ Yes ☐ No

6. Other than as already disclosed above, are you currently taking any medication prescribed by a licensed member of the medical profession, taking over the counter medication, or have you been treated by a licensed member of the medical profession for any medical or mental health of any kind? ☐ Yes ☐ No

7. To the best of your knowledge and belief have you been treated by a licensed member of the medical profession for any reason other than as already disclosed above? ☐ Yes ☐ No

8. To the best of your knowledge and belief have you, within the past 5 years:
   a. been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? ☐ Yes ☐ No
   b. used controlled substances including cocaine, heroin, amphetamines, barbiturates or hallucinogens that were not prescribed by a licensed member of the medical profession? ☐ Yes ☐ No
   c. been treated by or been advised by a licensed member of the medical profession to seek treatment for drug or alcohol use? ☐ Yes ☐ No
   d. been advised by a licensed member of the medical profession to have any test (except HIV tests), treatment, surgery, or hospitalization which has yet to be completed? ☐ Yes ☐ No
   e. had an application for life or health insurance rated up, postponed, declined or denied reinstatement? ☐ Yes ☐ No

9. To the best of your knowledge or belief has more than one natural parent or sibling died of cancer or heart disease prior to age 60? ☐ Yes ☐ No

10. Have you, within the past 24 months, used any form of tobacco or nicotine product, including cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or nicotine gum? ☐ Yes ☐ No
    If yes, have you, within the past 12 months, used any form of tobacco or nicotine product? ☐ Yes ☐ No

11. Have you, within the past 2 years, engaged in or, in the next 2 years do you plan to engage in:
    a. any aviation activity other than as a fare-paying passenger on commercial airlines? ☐ Yes ☐ No
    b. any form of scuba diving, hang-gliding, cave exploration, parachuting, mountain, rock or ice climbing, bungee jumping or organized motor racing? ☐ Yes ☐ No

12. Have you, within the past 2 years, had a driver's license suspended, revoked or been convicted of more than three moving violations? ☐ Yes ☐ No

13. Have you, within the past 5 years, been convicted of driving while under the influence of alcohol or drugs? ☐ Yes ☐ No

14. Are you currently on probation for a criminal offense or have you, within the past 5 years, been convicted of a felony? ☐ Yes ☐ No

PROVIDE DETAILS OF ANY YES ANSWERS ON THE PAGE 3.

B - DEPENDENT CHILD RIDER

LIST ALL DEPENDENT CHILDREN TO BE INSURED

If more space is needed, list full information on all additional dependent children on a separate, signed sheet.

B1. Full Legal Name of Dependent Child: _____ ☐ Male ☐ Female Date of Birth: _____ Age: ____
Place of Birth: _____ Relationship to the Proposed Insured: _____

B2. Full Legal Name of Dependent Child: _____ ☐ Male ☐ Female Date of Birth: _____ Age: ____
Place of Birth: _____ Relationship to the Proposed Insured: _____

B3. Full Legal Name of Dependent Child: _____ ☐ Male ☐ Female Date of Birth: _____ Age: ____
Place of Birth: _____ Relationship to the Proposed Insured: _____

B4. Full Legal Name of Dependent Child: _____ ☐ Male ☐ Female Date of Birth: _____ Age: ____
Place of Birth: _____ Relationship to the Proposed Insured: _____

B5. Does any Child to be insured have any existing life insurance in force or is there an application for life insurance now pending on any Child to be insured? *(If yes, please provide name of company and policy number.)*…….. ☐ Yes ☐ No
Name of Insurance Company:_____ Policy Number: _____

B6. If this coverage is issued, will any existing life insurance or annuity on any Child to be insured be cancelled, terminated, lapsed or not renewed? *If Yes, give full details below.* ..... ☐ Yes ☐ No

B7. To the best of your knowledge and belief, has any Child to be insured been diagnosed with or treated by a licensed member of the medical profession for any physical disability, mental retardation? ..... ☐ Yes ☐ No

B8. To the best of your knowledge and belief, has any Child to be insured been diagnosed with or treated by a licensed member of the medical profession for any disorder of the heart or has any surgery or hospitalization been suggested which has not yet been completed? ..... ☐ Yes ☐ No

PROVIDE DETAILS OF ANY YES ANSWERS BELOW.

DETAILS OF YES ANSWERES (IF ANY)

Show question being answered, the condition(s), the name, address and phone number(s) of the physician(s) and the prescribed medication(s).

Question Answer

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Name of Proposed Insured:

PREAUTHORIZED PAYMENT AUTHORIZATION

As a convenience to me, I authorize Fidelity Life Association, A Legal Reserve Life Insurance Company ("Fidelity Life") to make electronic debits or other forms of preauthorized withdrawals from my financial institution as indicated below. I understand that if a debit or withdrawal is not honored by the financial institution, Fidelity Life will consider the premium unpaid. Any debit or withdrawal returned due to insufficient funds may be redeposited by Fidelity Life. This authorization will remain in effect until written notice by the depositor/card holder is received by Fidelity Life. I further agree that if any such debit or withdrawal is not honored, whether with or without cause, Fidelity Life shall be under no liability whatsoever even though such dishonor results in the lapse of insurance, in accordance with the grace period.

PRE-AUTHORIZED CHECK

☐ I request that my premium payments be debited from my bank account as shown.
Name of Bank: _____ Transit Number: _____ Account Number: _____

PRE-AUTHORIZED CREDIT CARD

☐ I request that my premium payments be debited from the credit card shown below.
☐ Visa ☐ Amex ☐ MasterCard ☐ Discover Card Number: _____ Expiration Date: _____

_____ X _____
Printed Name *(As it appears on file with the financial institution)* AUTHORIZED SIGNATURE

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I declare that each answer and statements given to the questions contained in this application is complete and true to the best of my knowledge and belief. I understand and agree that Fidelity Life will rely on these answers, and the answers and statements I may give in any other form taken as a part of this application as representations and not warranties and that no such statement shall void the policy unless it is contained in a written application and a copy of such application shall be endorsed upon or attached to the policy when issued. I also understand that Fidelity Life reserves the right to accept or deny this application after taking into account whatever information may be available to it, including availability as to coverage by its reinsurers.

The coverage will be effective on its date of issue if the: (a) health; (b) avocations; (c) occupation; and (d) any other condition relating to the Proposed Insured are as described in the application. The effective date is the Policy Date shown on page 3.

I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (MIB), consumer reporting agency or employer to give to Fidelity Life any information they might have regarding the diagnosis, treatment, prescription and prognosis of any physical or mental condition, my driving record, avocations, credit history, insurance history, occupation, character and hobbies, as applicable. To facilitate the rapid transmission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by Fidelity Life to collect and transmit such information.

I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization shall be used to evaluate my application for insurance. I understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization. I also understand that I have the right to revoke this authorization at any time.

All or part of such information may be disclosed to a physician of my choosing, my insurance agent, the Medical Information Bureau (MIB), to other persons or organizations performing business or legal services in connection with this application, including reinsuring companies and as may be required by law.

Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signed at: (City and State)_____Date: _____

X _____ X _____
Signature of **Policyowner**, if other than the Insured Signature of **Proposed Insured**

AGENT

To the best of your knowledge, will the coverage applied for replace any existing life or annuity coverage now in force on the life of the Proposed Insured?..... ☐ Yes ☐ No
Does any Proposed Insured have existing life insurance policies or annuity contracts in force? ..... ☐ Yes ☐ No
If any Proposed Insured has existing life or annuity coverage complete the notice regarding replacements.

Printed Name of Agent: _____ Agent ID:_____ General Agent ID: _____

Email Address of Agent: _____ Telephone Number of Agent: _____

Florida License Number: _____(if required by law) Signature of Licensed Agent X _____

NOTICE OF INSURANCE INFORMATION PRACTICES

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Fidelity Life Association, A Legal Reserve Life Insurance Company

We appreciate your application and thank you for choosing **Fidelity Life Association** for your life insurance needs. In order for us to continue to provide cost effective coverage to our clients, we need to evaluate each application fully. To complete our underwriting evaluation, we may need to obtain medical and other personal information about you. When you sign the Declaration, Agreement and Authorization to Release Information section of the application, you give us permission to obtain that information and give permission to others who have that information to send it to us.

We recognize our obligation to protect your privacy and the confidentiality of underwriting information we obtain about you. For that reason, we have procedures for obtaining information and controlling access to our files that we want you to know about it. In addition, Federal and State regulators require that certain information about the underwriting process be given to you. This information is included in the following paragraphs.

Insurance Information Practices. To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. Although the information we obtain about you is confidential, in some cases we may disclose information to others without your specific authorization. We will furnish a more detailed summary of our information practices upon request.

Fair Credit Reporting. As part of our evaluation of your application, an investigative consumer report may be prepared, whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health and mode of living. Upon your written request and within a reasonable period of time, you have the right to receive additional information about the nature and the scope of the investigation and to receive a copy of the report at your expense.

Medical Information Bureau. Information regarding your insurability will be treated as confidential. Fidelity Life Association, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member for Life or Health insurance, or a claim for benefits is submitted to such a company MIB, upon request, will supply such company with the information 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 (TTY 866.346.3642). If you question the accuracy of any 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 the MIB's information office is Suite 400, 50 Braintree Hill Park, Braintree, Massachusetts 01284-8734.

Fidelity Life Association, or its reinsurers, may also release information in 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.

THIS NOTICE IS TO BE LEFT WITH THE APPLICANT

HIPAA AUTHORIZATION

Fidelity Life Association, A Legal Reserve Life Insurance Company

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Authorization for the Release of personal Health Information

This authorization complies with the **HIPAA** Privacy Rules

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any entity subject to the **Health Insurance Portability and Accountability Act** of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Fidelity Life Association, its agents, employees, representatives, any agency employed by the Company to collect and transmit Medical Records, and reinsurers (collectively, "the Company"). This includes all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including but not limited to, hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer and/or any entity subject to HIPAA to release and disclose such information without restriction.

I understand that unless prohibited by state and/or Federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application 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, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by Federal rules governing privacy and confidentiality of health information and may be subject to redisclosure.

This authorization shall remain in force for 26 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company at the address listed above. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application for insurance. I understand that I am entitled to receive a copy of this authorization.

PRINTED NAME OF THE PROPOSED INSURED _____ DATE OF BIRTH _____

SIGNATURE OF THE PROPOSED INSURED _____ DATED _____
Or, if applicable, signature of the Personal Representative of the Proposed Insured

If applicable, description of Personal Representative's authority or relationship to Proposed Insured. _____

THIS PAGE IS TO BE SIGNED AND SENT TO THE COMPANY