Application for Term Life Insurance

Fidelity Life Association, A Mutual Legal Reserve Company

FIDELITYLIFE
Established 1896

The Proposed Insured

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

Proposed Insured: *Give full legal name*	☐ Male ☐ Female

Date of Birth: *MM-DD-YYYY*	Age Last Birthday:	Place of Birth: *State or Country*

Legal Residence Address:	*City*	*State*	*Zip*

Social Security Number:	Driver's License Number & State:
Email Address:	Daytime Telephone:
Occupation(s):	Employer or Business Name:
Annual Earned Income: $	How Long With Current Employer:

Coverage Applied For

Plan Applied For:	Mode of Payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly
Face Amount Applied for: $	Billing Method: ☐ Direct Bill ☐ EFT ☐ Credit Card
Level Term Period: ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ __ Years	Premium Collected with the Application: $
Accidental Death Benefit Amount:	Waiver of Premium Benefit On Total Disability of the Insured: ☐ Yes ☐ No

Other Coverage

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

Name of Company	Face Amount	Month / Year Issued	To be Replaced?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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

Policyowner, Billing and Beneficiary

Name of Policyowner: (The Proposed Insured will be the Policyowner unless otherwise indicated) SSN or Tax ID of Policyowner

Billing Address: (All correspondence and notices will go to the legal residence address of the Proposed Insured unless otherwise indicated)

Secondary Addressee: (Optional. Used for the purpose of notification to a third party of a past due premium and possible lapse of coverage)

Primary Beneficiary:	Relationship to the Insured	SSN or Tax ID
Contingent Beneficiary:	Relationship to the Insured	SSN or Tax ID

If more space is needed for the Beneficiary designation, attach a signed and dated additional sheet of paper.

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Questions of the Proposed Insured

Name and Address of your Primary Physician:

Date last seen:	Reason and treatment:

Height: _______ ft./in. Weight: _______ lbs. | Have you lost weight in the past year? If more than 10 pounds was lost, explain below. ☐ Yes ________ lbs ☐ No

1. Are you currently taking any medication (by prescription or over the counter) or receiving medical or mental health treatment of any kind? ☐ Yes ☐ No
2. Has any natural parent or sibling been diagnosed with or died of cancer or heart disease prior to the age of 60? ☐ Yes ☐ No
3. Have you, within the past 10 years, been treated by a physician for or been diagnosed as having:
   a. chest pain, myocardial infarction (heart attack), blockage or narrowing of the arteries, irregular heart beat (arrhythmia), hypertension (high blood pressure), stroke, transient ischemic attack (TIA), thrombosis, aneurysm or any other disorder of the heart or blood vessels? ☐ Yes ☐ No
   b. diabetes, hyperthyroid, internal cancer or tumor, lymphoma, melanoma, leukemia, hepatitis or other liver disease, pancreatitis, kidney disease, urinary tract disorder or disorder of the breast? ☐ Yes ☐ No
   c. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
      NOTE: The reporting of HIV test results is limited to results of FDA-licensed tests. A positive test result obtained at anonymous counseling and testing sites and the results of home test kits need not be revealed.
   d. sleep apnea, cystic fibrosis, asthma, emphysema or other treatment for breathing or lung disorders? ☐ Yes ☐ No
   e. memory loss or dysfunction, seizures, psychological (emotional) or learning disorders? ☐ Yes ☐ No
   f. multiple sclerosis, rheumatoid arthritis, paralysis, cerebral palsy or connective tissue disorders (lupus or scleroderma)? ☐ Yes ☐ No
4. 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 such as cocaine, heroin, amphetamines, barbiturates or hallucinogens? ☐ Yes ☐ No
   c. been treated by or been advised by a physician to seek treatment for drug or alcohol use? ☐ Yes ☐ No
   d. been advised 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
5. 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
6. Have you, within the past 3 years, engaged in or 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 organized motor racing, scuba diving, hang-gliding, cave exploration, parachuting, mountain, rock or ice climbing, rodeo, bungee jumping or ballooning? ☐ Yes ☐ No
7. Have you, within the past 3 years, been convicted of driving while under the influence of alcohol or drugs or had a driver's license suspended or revoked? ☐ Yes ☐ No
8. Do you intend to travel, live or work outside the United States or Canada? ☐ Yes ☐ No
9. Are you currently on probation or have you, within the past 5 years, been convicted of a felony? ☐ Yes ☐ No

Details of Yes Answers

Provide full details of Yes answers, including the diagnoses, date, duration, and names and addresses of all attending physicians and medical facilities.

If more space is needed to provide details, attach a signed and dated additional sheet of paper.

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Preauthorized Payment Authorization and Agreement

As a convenience to me, I authorize **Fidelity Life Association** 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 at its sole discretion. 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.

☐ I request that my premium payments be debited from my bank account as shown on the attached voided sample check (No deposit slips accepted).
☐ I request that my premium payments be debited from the credit card shown below.

☐ Visa ☐ MasterCard	☐ American Express ☐ Discover	Card Number:	Expiration Date:

PRINTED NAME
(As it appears on file with the financial institution)

AUTHORIZED SIGNATURE
(As it appears on file with the financial Institution)

Declaration, Agreement and Authorization to Release Information

I declare that each answer 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 the Company 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. I also understand that the Company 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) habits; (c) occupation; and (d) any other condition relating to the Proposed Insured are as described in the application.

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 Association 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 the Company 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 or to evaluate a claim during the time that this authorization is valid. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization.

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.

SIGNED AND DATED AT: *(City, State and Date)*	SIGNATURE OF PROPOSED INSURED:
SIGNATURE OF LICENSED AGENT:	SIGNATURE OF THE POLICYOWNER: (If other than the Proposed Insured)

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of criminal offense under state law.

Agent: To the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of the Proposed Insured? (If Yes, complete appropriate State replacement forms) .... ☐ Yes ☐ No

PRINTED NAME OF AGENT:	STATE LICENSE NUMBER: (if required by law)
AGENT IDENTIFICATION:	GENERAL AGENT AND IDENTIFICATION:

NOTICE OF INSURANCE INFORMATION PRACTICES

Fidelity Life Association, A Mutual Legal Reserve 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

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.

<u>THIS NOTICE IS TO BE LEFT WITH THE APPLICANT</u>

HIPAA AUTHORIZATION

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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, insurance support organizations, 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 Acquired Immune Deficiency Syndrome (AIDS), or AIDS related Complex (ARC)) 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.

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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.

<u>THIS PAGE IS TO BE SIGNED AND SENT TO THE COMPANY</u>