Application for Graded Death Benefit 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: ______________________________

Telephone Number: ______________ Best Time to Call (if needed): ______________

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: _____ ☐ I do not have a driver's license (explain below)

Occupation & Employer: ______________________ Annual Income: $ __________

COVERAGE

Plan: ☐ Graded Death Benefit Whole Life
☐ Graded Death Benefit 10 Year Term
☐ Graded Death Benefit 20 Year Term
☐ Graded Death Benefit 30 Year Term

Automatic Premium Loan Option on GDB Whole Life? ☐ Yes ☐ No

☐ Other: ______________________

Face Amount: $ ______________ Accidental Death Benefit Rider Amount: $ ______________

Other: ______________ Other: ______________

OWNER BENEFICIARY

Policyowner: *(if not the Proposed Insured)*______________ SSN or Tax ID of Policyowner: __________

Billing Address: ______________________________

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

Name: ______________ Mailing Address: ______________________

Beneficiary: ______________________ Relationship to Insured: ______________

QUESTIONS OF THE PROPOSED INSURED

The Proposed Insured will qualify for a Graded Death Benefit plan, subject to age and underwriting guidelines, if the answers to questions 2 and 3 are No.

1a. Your Height: ________ ft/in 1b. Your Weight: ________ lbs.

2. Have you been diagnosed as having or been treated by a licensed medical professional for:
   a. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
   b. Alzheimer's disease (dementia), Amyotrophic Lateral Sclerosis (ALS), mental retardation or Down's Syndrome or do you require the assistance of another person for dressing, bathing, toileting, or mobility or do you use an oxygen tank?............ ☐ Yes ☐ No
3. Have you, within the past **2** (two) years:
   a. had a heart attack (myocardial infarction) or stroke (cerebral vascular accident)? .... ☐ Yes ☐ No
   b. had or are now awaiting an organ or bone marrow transplant (except as a donor)? .... ☐ Yes ☐ No
   c. been diagnosed with cancer, received or been prescribed radiation or chemo therapy or have you received or been prescribed dialysis? .... ☐ Yes ☐ No
   d. been confined to or been advised by a licensed medical professional to be admitted to, a nursing home, hospice, extended care or special treatment facility or are you now hospitalized? .... ☐ Yes ☐ No
   e. used controlled substances such as cocaine, heroin, amphetamines, barbiturates or hallucinogens except as prescribed by a licensed medical professional or been treated for or been advised by a licensed medical professional to seek treatment for drug or alcohol use? .... ☐ Yes ☐ No
   f. been advised by a licensed medical professional that your life expectancy is less than 24 months? .... ☐ Yes ☐ No
   g had more than one DUI (DWI) violation, been convicted of a felony or are you now on probation? .... ☐ Yes ☐ No
4. Do you have any existing life insurance or annuity now in force? *(If Yes, describe in Details section)* .... ☐ Yes ☐ No
5. Will the issuance of this policy result in the replacement, lapse or termination of any existing life insurance or annuity? *(If Yes, complete and submit the appropriate State Replacement forms.)* .... ☐ Yes ☐ No

Details of Yes answers

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PAYMENT MODE AND METHOD

MODE OF PAYMENT: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (no Direct Billing available for monthly mode)

DIRECT BILLING

☐ I request premium notices be sent to the Residence Address of the Proposed Insured or to the Billing Address (if any) listed on page 1.

PRE-AUTHORIZED CHECK (EFT)

☐ 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: __________

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 above. 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.

____ X____

Printed Name *(As it appears on file with the financial institution)* AUTHORIZED SIGNATURE *(Pre-Authorized Check and Credit Card Only)*

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

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 information given in the application is true on that date. The effective date is the Policy Date shown on page 3, provided one is issued.

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 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.

____ X____

Signed and Dated at (City and State) Signature of Proposed Insured

X____ X____

Signature of Licensed Agent Signature of Policyowner, if other than the 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? (If Yes, complete appropriate State replacement forms)... ☐ Yes ☐ No

Does any Proposed Insured have existing Life Insurance or Annuity contracts in force? .... ☐ Yes ☐ No

Printed Name of Agent: ____________________________ Agent ID: ___________ General Agent ID: ___________

State License Number: __________ (If required by law) Agent Email: ______________________ Agent Telephone:_______________

NOTICE OF INSURANCE INFORMATION PRACTICES

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. No information concerning your sexual orientation will be used to determine your eligibility for insurance. 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.

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

HIPAA AUTHORIZATION

Fidelity Life Association, A Legal Reserve Life Insurance Company

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 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.

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