APPLICATION FOR INDIVIDUAL SUPPLEMENTAL LIFE INSURANCE –
Dependent Child Rider Application

☐ FIDELITY LIFE ASSOCIATION, A LEGAL RESERVE LIFE INSURANCE COMPANY
{8700 W BRYN MAWR AVE, SUITE 900S, CHICAGO, IL 60631}

{☐ New Issue ☐ Reinstatement of Policy # _____ }

PROPOSED INSURED

Full Legal Name of the Proposed Insured
(The Proposed Insured must be the parent or legal guardian of the child/children to be insured.)

Full Legal Name of the Proposed Child to be Insured | Gender | Height (ft/In) | Weight (lbs)

Date of Birth | {Place of Birth (Country/State)} | Relationship to the Proposed Insured

COVERAGE

Plan Name | {Plan Type}

Insurance Amount ($)

OTHER INSURANCE

Does the Proposed Child (Children) to be Insured have any existing life insurance or annuity contracts in force or is any application for life insurance, or reinstatement now pending with any insurance company? .....☐Yes. ☐ No.

If this coverage is issued, will any other existing life insurance or annuity contract be cancelled, lapsed or not renewed, or will funds from your existing policies or contracts be used to pay premiums on the new policy or contract? ..... ☐Yes. ☐ No.

{Name of Company} {Policy ID / Number} {Insurance Amount} {($)} {Date Issued} {To Be Replaced} {☐Yes. ☐ No.} {To Be Financed} {☐Yes. ☐ No.}

{Name of Company} {Policy ID / Number} {Insurance Amount} {($)} {Date Issued} {To Be Replaced} {☐Yes. ☐ No.} {To Be Financed} {☐Yes. ☐ No.}

OWNER

Name | Type of Owner | [Date of Birth] | [Date of Trust Agreement] | [SSN] | [EIN]

[Address] | [Relationship to Proposed Insured]

[Preferred Phone]
[Number] **[**Phone Type] [Best Time to Call]

[Alternate Phone]
Number] **[**Phone Type] [Best Time to Call]

[Phone # for Texts] [Email Address]

[Other Contact Options]

Name of Proposed Insured

BENEFICIARY

Primary Beneficiary Type of Beneficiary	Name	[Date of Birth]	[Date of Trust Agreement]	[SSN]	[EIN]
[Address]	[Phone Number]	% of Benefit	[Relationship to Insured]		

[Contingent Beneficiary] [Type of Beneficiary]	[Name]	[Date of Birth]	[Date of Trust Agreement]	[SSN]	[EIN]
[Address]	[Phone Number]	[% of Benefit]	[Relationship to Insured]		

QUESTIONS TO THE PROPOSED INSURED

1. [Is any Proposed Child (Children) to be Insured now taking medication, by prescription or over the counter (OTC)? ☐ Yes. ☐ No.]
2. [Is any Proposed Child (Children) to be Insured undergoing treatment or therapy of any kind by a member of the medical profession?..... ☐ Yes. ☐ No.]
3. [Has any Proposed Child (Children) to be Insured [ever] been diagnosed with or treated by a physician for any physical disability? ..... ☐ Yes. ☐ No.]
4. [Has any Proposed Child (Children) to be Insured [ever] been diagnosed with or treated by a physician for any mental disability? ..... ☐ Yes. ☐ No.]
5. [Has any Proposed Child (Children) to be Insured [ever] been diagnosed with or treated by a physician for any disorder of the heart? ..... ☐ Yes. ☐ No.]
6. [Has any Proposed Child (Children) to be Insured [ever] been diagnosed with or treated by a physician for any disorder of the lung? ..... ☐ Yes. ☐ No.]
7. [Has any Proposed Child (Children) to be Insured [ever] been diagnosed with or treated by a physician for cancer? ..... ☐ Yes. ☐ No.]
8. [Within the last [5 years], has any Proposed Child (Children) to be Insured been advised by a member of the medical profession to have any surgery which has not yet been completed? ..... ☐ Yes. ☐ No.]
9. [Within the last [5 years], has any Proposed Child (Children) to be Insured been advised by a member of the medical profession to have any hospitalization which has not yet been completed? ..... ☐ Yes. ☐ No.]

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I, the parent or legal guardian of the Proposed Child (Children) to be Insured, declare that each answer and statement given to the questions contained in this application is complete, true and correctly recorded to the best of my knowledge and belief. I understand and agree that this application and my answers and statements in it will be shared with {Agency Name and} the insurer(s) named on page one (the "Insurer(s)") for the purpose of determining insurability and ultimately obtaining securing offers of insurance coverage from the Insurer(s) on the life of the Proposed Child (Children) to be Insured. The Insurer(s) named in this application 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. No answer or statement shall void the policy rider, if issued, unless the answer or statement is contained in a written application which has been endorsed and attached to the policy. I also understand that the Insurer(s) reserve(s) the right to accept or deny this application after taking into account whatever information may be available to it, including availability of coverage by its reinsurers.

I understand that the statements and answers in this application are the basis for the policy rider, if issued, and that no information will be considered to have been given to the Insurer(s) unless it is stated in the application. I understand that {Agency Name and} their representatives do not have authorization of the Insurer(s) to accept risk, pass on insurability, or make, void, waive, or change any conditions or provisions of the application, policy, policy rider, or receipt, as applicable.

I understand that no Insurer(s) will have any liability until a policy rider is issued on this application, that policy and policy rider is delivered to and accepted by the Owner and the first premium is paid in full while the Proposed Child (Children) to be Insured is alive.

I, the parent or legal guardian of the Proposed Child (Children) to be Insured, authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, MIB, Inc., consumer reporting agency or employer to provide to the Insurer(s), or their reinsurers or other designee, for underwriting purposes, any information they might have about the Proposed Child (Children) to be Insured regarding the diagnosis, treatment, prescription, and prognosis of any physical or mental condition, the Proposed Child (Children) to be Insured's 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 MIB, Inc., to give such records to any agency employed by the Insurer(s).

I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed or a time limit that complies with the time limit, if any, permitted by applicable law in the state where the policy rider is delivered or issued for delivery 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 this application for insurance. I also 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. A written statement revoking this Authorization delivered to {Agency Name or} the Insurer(s) at its usual business address will revoke this Authorization.

All or part of the information obtained with this Authorization may be disclosed to a physician of my choosing, my insurance agent, MIB, Inc., and 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.

I authorize the Insurer(s) or reinsurers to make a brief report of the Proposed Child (Children) to be Insured's protected health information to MIB, Inc.

I hereby acknowledge that this application constitutes an invitation to the Insurer(s) to make an offer of life insurance coverage. I further acknowledge that the Insurer(s) is (are) in no way obligated to extend such an offer. I understand that, if an offer is made, no coverage is in place until I receive and accept the policy and policy rider and pay the required initial premium.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION (continued)

Signed this Date _____ City _____ State _____

{Printed Name of Proposed Insured}

_____

Signature of Proposed Insured _____ {Reference #} _____

{Printed Name of Owner if other than Proposed Insured}

_____

{Signature of Owner if other than Proposed Insured} _____ {Reference #} _____

PRODUCER STATEMENT

{To the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of any proposed insured?
☐ Yes. ☐ No.}

{Does any Proposed Child (Children) to be Insured Insured have existing life insurance or annuity contracts in force?
☐ Yes. ☐ No.}

Writing Agent Name Writing Agent ID {State License Identification Number}

{Email Address of Writing Agent} {Telephone Number of Writing Agent}

{General Agent Name} {General Agent ID}

{Assistant Licensed Agent Name} {Assistant Licensed Agent ID}

Writing Agent Signature _____ {Reference #} _____