Fidelity Life Association, A Legal Reserve Life Insurance Company

Application for Individual Life Insurance
LifeStory Term

FIDELITYLIFE
Established 1896

■ NEW ISSUE

PROPOSED INSURED

Full Legal Name of the Proposed Insured _____ Gender: _____

Legal Residence Address: _____

Best Time to Call: _____ Preferred #: _____ Alternate #: _____

Email Address: _____

Date of Birth: _____ Place of Birth (Country): _____ Social Security Number: _____

Drivers License Number: _____ State of Issue: _____

COVERAGE

Face Amount: $_____

Term Period: ☐ 10 years ☐ 15 years ☐ 20 years ☐ 30 years

☐ Accidental Death Benefit: $ _____

☐ Dependent Child Rider: $ _____

☐ Waiver of Premium on Total Disability Rider

OTHER COVERAGE

Do you have any existing life insurance or annuity contracts in force or is any application for life insurance or reinstatement, now pending with Fidelity Life or any other company? ..... ☐ Yes. ☐ No.

If this policy is issued, will any other existing life insurance or annuity with Fidelity Life or any other company be cancelled, terminated, lapsed or not renewed ?..... ☐ 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.

POLICY OWNER

Policyowner *(Different than the Proposed Insured)*

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

Policyowner Address: _____

Trust Name: _____ Authorized Signature Name: _____

SSN/Tax ID: _____

Policyowner Address: _____

SECONDARY ADDRESSEE

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

Secondary Addressee Name: _____

Secondary Mailing Address: _____

NAME OF PROPOSED INSURED:

MAILING ADDRESS

Mailing Address *(The address to which the policy should be sent.)*

Mailing Address:_____

BENEFICIARY

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

Primary: _____	% of Benefit: _____	Relationship to Insured: _____	SSN/Tax ID: _____
Primary: _____	% of Benefit: _____	Relationship to Insured: _____	SSN/Tax ID: _____
Contingent: _____	% of Benefit: _____	Relationship to Insured: _____	SSN/Tax ID: _____

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NAME OF PROPOSED INSURED:

QUESTIONS TO THE PROPOSED INSURED

For any 'Yes' response, additional information may be requested:

1. Is the Proposed Insured completing this application and paying the premium? ☐ Yes ☐ No
2. Are you a legal U.S. resident and have you resided in the U.S. for more than 2 years? ☐ Yes ☐ No
3. Are you currently employed? ☐ Yes ☐ No
4. Do you have a Primary Care Physician? ☐ Yes ☐ No
5. Have you seen a Physician within the past 5 years? ☐ Yes ☐ No
6. What is your Height? _____ ft/in
7. What is your Weight? _____ lbs
8. Has your weight changed in the past year? ☐ Yes ☐ No
9. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Congestive Heart Failure (CHF), Malignant Neoplasm, Lymphoma, Multiple Sclerosis, Muscular Dystrophy, Muscular Atrophy, Myasthenia Gravis, Parkinson's Disease, Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease), Systemic Lupus Erythematosus (SLE), Lupus, Scleroderma, Cystic Fibrosis, Alzheimer's Disease, Schizophrenia, Dementia or Mental Retardation (including Down's Syndrome) OR any disease or disorder of the Liver? ☐ Yes ☐ No
10. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
11. Have you ever received a positive result from a test administered by a member of the medical profession for Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No
12. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; a Tumor or Cancer (excluding basal cell or squamous cell carcinoma of the skin), Melanoma or Leukemia, Aneurysm, Circulatory Disorder, or any other Disease or Disorder of the Heart or Peripheral Vascular System? ☐ Yes ☐ No
13. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Irregular Heart Beat (Arrhythmia), Blockage or Narrowing of the Arteries or Stroke, Atherosclerosis, Coronary Artery Disease (CAD), Pancreatitis, Cerebral Palsy, OR any disease or disorder of the Kidney (other than kidney stones)? ☐ Yes ☐ No
14. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Chest Pain, Heart Murmur, Heart Attack (Myocardial Infarction), Transient Ischemic Attack (TIA or mini stroke), Thrombosis, Rheumatoid Arthritis, Paralysis, or any other Disease or Disorder of the Coronary Arteries? ☐ Yes ☐ No
15. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Chronic Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea, Emphysema, Asthma, Learning Disorders, Bipolar disease, major Depression or Anxiety that required psychiatric treatment, Drug or Alcohol abuse, or other Nervous Disorder? ☐ Yes ☐ No
16. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Diabetes or Elevated Blood Sugar, Elevated Cholesterol, Hypertension (High Blood Pressure), Seizures, Hepatitis, Crohn's Disease, Colitis, Abnormal PAP Test, Anemia, or any Disorder of the Bladder, Stomach, or Prostate? ☐ Yes ☐ No
17. Have you, within the past 5 years, been treated for, advised to Discontinue, Decrease or seek treatment for Drug or Alcohol Use? ☐ Yes ☐ No
18. Do you currently take more than 2 prescription medications for pain; or do you consume, on average, more than 3 alcoholic beverages per day? ☐ Yes ☐ No
19. Have you, within the past 5 years, used Controlled Substances such as Narcotics, Cocaine, Heroin, Marijuana, Amphetamines, Hallucinogens or Barbiturates not prescribed by a Physician or have you abused over the counter Medications? ☐ Yes ☐ No

NAME OF PROPOSED INSURED:

QUESTIONS TO THE PROPOSED INSURED (Continued)

20. Have you, within the last 24 months, used any form of Tobacco, Nicotine or Nicotine Products of any kind? ☐ Yes ☐ No
21. Have you, within the past 5 years, been admitted to an Emergency Room (ER) or Urgent Care Facility, or been a patient in any Hospital, Clinic, Nursing Home, Assisted Living Facility or other Medical Facility? ☐ Yes ☐ No
22. Have you, within the past 5 years, been advised by a member of the medical profession to have any Diagnostic Tests (except HIV tests), Treatments, Hospitalizations, Surgical Operations or medical or mental evaluations or consultations with any Medical Professionals, which have yet to be completed, or are you waiting for a diagnosis? ☐ Yes ☐ No
23. Within the past 5 years, have you been prescribed any medication, suffered from any disease or received any Medical, Mental or Surgical health treatment for any condition that you have not previously disclosed? ☐ Yes ☐ No
24. Have you, within the past 5 years, had an Application for Life or Health Insurance Rated Up, Postponed, Declined or Denied Reinstatement? ☐ Yes ☐ No
25. Have you, within the past 5 years, been convicted of or pled guilty to a Felony or misdemeanor or been incarcerated or served in a probation or parole program or do you have criminal charges pending? ☐ Yes ☐ No
26. Have you, within the past 5 years, had a Drivers License Denied, Suspended, Revoked or been convicted of more than three Moving Violations? ☐ Yes ☐ No
27. Have you, within the past 5 years, been convicted of or pled guilty to Reckless Driving or Driving while Under the Influence of Alcohol or Drugs or driving while intoxicated? ☐ Yes ☐ No
28. Have you, within the past 2 years, engaged in, or do you plan within the next 2 years to engage in, any Aviation Activity other than as a Fare-Paying Passenger on commercial airlines? ☐ Yes ☐ No
29. Have you, within the past 2 years, engaged in, or do you plan within the next 2 years to engage in, any form of, Skin or Scuba Diving, Hang-Gliding, Ultralight Flying, Cave Exploration, Parachuting or Sky Diving, Mountain, Rock or Ice Climbing, Rodeo, Bungee Jumping, Ballooning, Competitive Skiing, Snowmobiling , Snowboarding or Motor Racing.? ☐ Yes ☐ No
30. To the best of your knowledge or belief has any Natural Parent or Sibling died of Diabetes, Cancer or Heart Disease prior to age 60? ☐ Yes ☐ No
31. Do you intend to Travel, Live or Work outside the United States or Canada within the next 2 years? ☐ Yes ☐ No
32. Have you, within the last 12 months, been subject of any voluntary or involuntary bankruptcy proceedings or are you currently in bankruptcy? ☐ Yes ☐ No
33. Are you a member of the armed forces including the reserves and are you currently or expecting to be Deployed outside of the US? ☐ Yes ☐ No
34. Have you, within the past 5 years, been treated by a Physician for, or been diagnosed as having Gaucher's Disease? ☐ Yes ☐ No

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NAME OF PROPOSED INSURED:

DEPENDENT CHILD RIDER

Dependent Children to be Insured:

Full Legal Name of Dependent Child: _____ Gender: _____ Date of Birth: _____

Full Legal Name of Dependent Child: _____ Gender: _____ Date of Birth: _____

Full Legal Name of Dependent Child: _____ Gender: _____ Date of Birth: _____

1. Has any Child to be insured have been diagnosed with, or treated by a Physician for any Physical Disability, Mental Retardation or Special Need? ..... ☐ Yes. ☐ No.
2. Has any Child to be insured been diagnosed with, or treated by a Physician for any Disorder of the Heart, or has any Surgeries or Hospitalization been suggested, which has yet to be completed? ..... ☐ Yes. ☐ No.

ADDITIONAL INFORMATION

Additional Information from the Proposed Insured(s):

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 re-deposited 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, in accordance with the grace period.

Payor is _____

Name of Payor: _____ Payor Address: _____

Mode of Payment: _____ Draw Date (Day of the Month): _____

Payment Method: _____

Amount paid with application: $_____

PRE-AUTHORIZED CHECK *(This selection will apply to all payments)*

I request that my premium payments be debited from my bank account as shown.

Name of Bank: _____ Transit Number: _____ Account Number: _____

PRE-AUTHORIZED CREDIT / DEBIT CARD *(This selection will apply to all payments)*

I request that my premium payments be debited from the _____ shown below.

Card Type: _____ Card Number: _____ Expiration Date: ____

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

Electronically Signed By: _____
AUTHORIZED SIGNATURE

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NAME OF PROPOSED INSURED:

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 the Fidelity Life Association, A Legal Reserve Life Insurance Company (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 the 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.
I understand that the statements and answers in the application are the basis for any policy issued by Fidelity Life, and that no information will be considered to have been given to the company unless it is stated in the application;

I understand that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

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 will be shown on page 3 of the Policy, provided one is issued.
I understand that Fidelity Life will have no liability until a policy is issued on this application and delivered to and accepted by the owner and the first premium is paid in full while the insured is alive.

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 MIB, Inc., 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, Inc., to give such records or knowledge to any agency employed by the Fidelity Life to collect and transmit such information. I authorize Fidelity Life or its reinsurers to make a brief report of my protected health information to MIB, Inc.

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 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.

All or part of such information may be disclosed to a physician of my choosing, my insurance agent, the MIB, Inc., 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 and subject to penalties under state law.

Signed at: _____ Date: _____

Electronically Signed By: _____
Signature of Proposed Insured

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 any 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: _____

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

Electronically Signed By: _____
Signature of Licensed Agent:

Medical and Background Supplemental Detail

PROPOSED INSURED: **POLICY NO:**