APPLICATION FOR INDIVIDUAL LIFE INSURANCE

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

☒ New Issue

PROPOSED INSURED

Full Legal Name of the Proposed Insured
sdf sdf

Gender
Male

Legal Residence Address
123 Main Street
Chicago, Ohio (OH) 60601

Preferred Phone Number
3094824902

Email Address
sdf@sdf.com

Date of Birth
1/1/1990

Place of Birth (Country/State)
United States Alabama (AL)

SSN
*****4902

Driver's License Number
sdf

State of Issue
South Carolina (SC)

COVERAGE

Plan Name
Rapid Decision Life

Insurance Amount ($)
250000

Term Period (years)
10-year

Rider Options

☒ **None**

Name of Proposed Insured
sdf sdf

OTHER INSURANCE

Do you 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 policy is issued, will any other existing life insurance or annuity contract be cancelled, lapsed or not renewed, or are you considering using funds from your existing policies or contracts to pay premiums on the new policy or contract? ..... ☐ Yes. ☒ No.

OWNER

Name
sdf sdf

Type of Owner
Proposed Insured

Address

Preferred Phone Number

SECONDARY ADDRESSEE

Do you want to provide a secondary addressee (*This person will receive copies of your overdue premium and lapse notices*) ..... ☐ Yes. ☒ No.

BENEFICIARY

Primary Beneficiary

Type of Beneficiary
Person

Name
s d

Phone Number
Not Provided

% of Benefit
100

Relationship to Insured
Spouse

QUESTIONS TO THE PROPOSED INSURED

1.	**What is your height (ft/in)?** 6' 1" **What is your weight (lbs)?** 170		
2.	Have you consulted a physician within the past 5 years?	☐ Yes.	☒ No.
3.	Are you a United States citizen?	☒ Yes	☐ No
4.	Are you currently employed?	☒ Yes	☐ No
	• My occupation is accountant.		
	• My annual income is $100,000.		
5.	Has your weight changed more than 10 pounds within the past year?	☐ Yes	☒ No
6.	Within the past 5 years have you used tobacco or any other product that contains nicotine?	☐ Yes	☒ No
7.	Within the past 2 years have you engaged in, or within the next 2 years do you expect to engage in:		
	a. any aviation activity other than as a passenger on a scheduled airline?	☐ Yes	☒ No
	b. any form of motor racing, mountain, rock or ice climbing, cave exploration, hang gliding, scuba or sky diving?	☐ Yes	☒ No
8.	Within the next 2 years, do you plan to travel or reside outside the United States?	☐ Yes	☒ No
9.	Within the past 5 years have you:		
	a. had your driver's license suspended or revoked?	☐ Yes	☒ No
	b. pled guilty to or been convicted of reckless driving or driving under the influence of alcohol or drugs?	☐ Yes	☒ No
	c. pled guilty to or been convicted of any moving violations?	☐ Yes	☒ No
10.	Within the past 10 years have you:		
	a. used marijuana, cocaine, heroin, narcotics, hallucinogens or other controlled substances (not prescribed by a physician)?	☐ Yes	☒ No
	b. been counseled, treated, or advised by a physician to discontinue or seek treatment for use of illegal drugs, alcohol or prescription drugs?	☐ Yes	☒ No
	c. pled guilty to or been convicted of any felony?	☐ Yes	☒ No
11.	Within the past 5 years have you:		
	a. received any kind of disability benefits, workman's compensation or long term care benefits?	☐ Yes	☒ No
	b. had an application for health or life insurance, rated up, postponed or declined?	☐ Yes	☒ No
12.	Have you ever been convicted in, or pled guilty to a criminal proceeding or do you have criminal charges pending?	☐ Yes	☒ No
13.	Within the past 10 years have you been diagnosed, been treated, been tested, consulted with, or been given medical advice by a member of the medical profession for:		
	a. cancer (other than basal cell skin cancer), tumor, polyp, leukemia, lymphoma or melanoma or any other malignancy?	☐ Yes	☒ No
	b. anemia or any other disorder of the blood, blood vessels or peripheral vascular system?	☐ Yes	☒ No
	c. elevated blood pressure or elevated cholesterol?	☐ Yes	☒ No
	d. heart attack, stroke, chest pain, coronary artery disorder, heart murmur, transient ischemic attack (TIA), irregular heartbeat, myocarditis or any other disorder of the heart?	☐ Yes	☒ No

e. ulcerative colitis, hepatitis, disorder of the esophagus, intestines, liver disorder or any other digestive disorder? ☐ Yes ☒ No

f. diabetes, elevated blood sugar, thyroid, adrenal, pituitary or pancreas disorder or any other gland or endocrine disorder? ☐ Yes ☒ No

g. kidney disorder, bladder disorder, prostate disorder, disorder of the breast or any other disorder of the urinary tract or the reproductive system, or any sexually transmitted disease? ☐ Yes ☒ No

h. asthma, shortness of breath, chronic bronchitis, chronic obstructive pulmonary disease (COPD), cystic fibrosis, emphysema, Acute Respiratory Distress Syndrome (ARDS), sleep apnea or any other respiratory disorder or required the use of a ventilator? ☐ Yes ☒ No

i. any muscle, neck, back, spine, bone or joint disorder, or disorder of the skin? ☐ Yes ☒ No

j. Alzheimer's disease, dementia, organic brain syndrome, cognitive impairment (of any degree), or amyotrophic lateral sclerosis (ALS), seizures, paralysis, multiple sclerosis, dizziness or any other nervous disorder? ☐ Yes ☒ No

k. anxiety, depression or any other mental or psychiatric disorder, or attempted suicide? ☐ Yes ☒ No

l. lupus, scleroderma, rheumatoid arthritis or any other connective tissue or immune system disorder (other than related to HIV/AIDS)? ☐ Yes ☒ No

m. any organ transplant or diabetic complications (amputation, coma, or blindness)? ☐ Yes ☒ No

14. Within the past 3 months have you been diagnosed or been treated by a member of the medical profession, for COVID-19 or any other viral disorder other than a cold or flu? ☐ Yes ☒ No

15. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (HIV)? ☐ Yes ☒ No

16. Within the past 5 years, have you been advised by a member of the medical profession, to have any hospitalization, surgery or medical test (other than related to HIV/AIDS) that has not yet been completed? ☐ Yes ☒ No

17. Within the past 2 years have you been advised by a member of the medical profession to have any medical appointment that has not yet been completed? ☐ Yes ☒ No

18. Within the past 5 years have you been diagnosed with, consulted a member of the medical profession or been treated or been prescribed a medication for any other disease, disorder or condition, or had surgery, hospitalization or medical test (other than related to HIV/AIDS) not mentioned in this application? ☐ Yes ☒ No

19. Within the past 5 years, in addition to the information already given have you had any medical tests (other than related to HIV/AIDS) or procedures, stress tests, echocardiograms, x-rays, CAT scan or MRI? ☐ Yes ☒ No

20. Have either of your natural parents, or has any sibling been diagnosed with, or died from, cancer, diabetes or heart disease before the age of 60? ☐ Yes ☒ No

PAYMENT PLAN

As a convenience to me, I authorize the insurer named on page one (the "Insurer") to make electronic debits or other forms of preauthorized withdrawals from my financial institution as indicated below or otherwise provided. I understand that if a debit or withdrawal is not honored by the financial institution, the Insurer will consider the premium unpaid. Any debit or withdrawal returned due to insufficient funds may be re-deposited by the Insurer at their sole discretion. This authorization will remain in effect until written notice by the depositor/card holder is received by the Insurer. I further agree that if any such debit or withdrawal is not honored, whether with or without cause, the Insurer shall be under no liability whatsoever even though such dishonor results in the lapse of insurance, in accordance with the grace period.

Payor Name
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Type of Payor
Proposed Insured or Spouse

Initial Payment

Payment Mode
Monthly

Payment Method
Credit or debit card

Recurring Payment

☒ **Same as Initial**

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I 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 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 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, 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, 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 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, or receipt, as applicable.

I understand that no Insurer(s) will have any liability until a policy is issued on this application, that policy is delivered to and accepted by the Owner and the first premium is paid in full while the Proposed 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, 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 me 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 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 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 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. A written statement revoking this Authorization delivered to 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 my protected health information to MIB, Inc.

In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score

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 pay the required initial premium.

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

Name of Proposed Insured
sdf sdf

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION (continued)

Signed this	Date	City	State
		Chicago	Ohio (OH)

Printed Name of Proposed Insured

sdf sdf

Signature of Proposed Insured

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 Insured have existing life insurance or annuity contracts in force? ☐ Yes. ☒ No.

Writing Agent Name
KRIS BRYANT

Writing Agent ID
007

State License Identification Number
OHLSN1234

Email Address of Writing Agent
fidelitylifeassociation@gmail.com

Telephone Number of Writing Agent
3125551200

General Agent Name
ANGELINA NOTTE

General Agent ID
ang123

Writing Agent Signature
Electronically signed by: KRIS BRYANT

Reference #

FIDELITYLIFE