

**PART A - THE PROPOSED INSURED**

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: *If US, show State otherwise show Country*

Legal Residence Address:      City      State      Zip

Social Security Number:      Driver's License Number & State:

Email Address:      Telephone number and best time to call:

Occupation(s):      Employer or Business Name:

**PART B - COVERAGE APPLIED FOR**

Accidental Death Amount Applied for: \$

Mode of Payment:  Annual       Semi-Annual  
 Quarterly       Monthly (EFT or Credit Card only)

Billing Method:  Direct Bill       Credit Card  
 EFT (Automatic Bank Withdrawal)

Family Accidental Death Benefit Rider:  Yes  No  
 Inflation Benefit Rider:  Yes  No  
 Other Rider: \_\_\_\_\_  Yes  No

Total Premium Paid With Application: \$

**PART C - OTHER COVERAGE**

1. 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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

*If more space is needed to list other coverage, attach a signed and dated additional sheet of paper.*

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

**PART D - 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

**PART E - 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 below or on the attached voided sample check.

Name of Bank	City & State	Routing Number:	Account Number:
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I request that my premium payments be debited from the credit card shown below.

<input type="checkbox"/> Visa	<input type="checkbox"/> American Express	Card Number:	Expiration Date:
<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover		

\_\_\_\_\_  
 PRINTED NAME (As it appears on file with the Bank or Credit Card)

\_\_\_\_\_  
 AUTHORIZED SIGNATURE (As it appears on file with the Bank or Credit Card)

**PART F - DECLARATION AND AGREEMENT**

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) habits; (b) occupation; and (c) any other condition relating to the Proposed Insured are as described in the application.

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 and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**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

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 Legal Reserve Life Insurance Company



Established 1896

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 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.

**THIS NOTICE IS TO BE LEFT WITH THE APPLICANT**

# CONDITIONAL RECEIPT

Fidelity Life Association, A Legal Reserve Life Insurance Company



Established 1896

***DO NOT complete and give to Applicant UNLESS the first full premium payment is made.***

In exchange for the payment of the first required premium with the application, the Company will provide insurance prior to policy delivery, under the following terms.

No insurance will be provided under this Receipt unless all requirements are first fulfilled exactly during the lifetime of the Proposed Insured. If all requirements are not so met, or the Proposed Insured dies by suicide, the liability of the Company shall be limited to a refund to the Applicant of the payment made for this Receipt. Medical requirements are defined by the Company's current rules and practices and include hospital and physician reports, and medical examinations and tests. No agent may alter or waive any part of this Receipt. This Receipt provides no insurance for riders or additional benefits.

### Requirements

The following must first be fulfilled for insurance to start:

- a. All medical requirements are completed and received by the Company within 60 days from the date of the application;
- b. The first premium has been paid in full;
- c. All questions in the application have been answered;
- d. All answers given in the application are true and complete; and
- e. The Proposed Insured is acceptable to the Company under its rules and practices, for the plan and amount applied for, without amendment, at the rate class applied for or a lesser premium, as of the date the Company receives all of its medical requirements.
- f. The Proposed Insured has complied with all parts of the Life Application.

### Start of Insurance

If the above requirements are first met, this Receipt will provide insurance beginning the latest of: (1) the date of the application; or (2) the date of receipt of all medical requirements by the Company.

### End of Insurance

Once begun, any insurance this Receipt may provide ends at the earliest of: (1) 60 days after the date of the application; (2) when the Company sends a refund of the premium which was exchanged for this Receipt; or, (3) the date any policy issued goes into effect.

### Amount Limit

The amount of insurance provided by this Receipt is the lesser of: (a) the initial death benefit of the insurance applied for in the application; or (b) \$500,000 less all amounts of life insurance and accidental death benefits applied for or in force with the Company.

### Payment Terms

The first premium will not be considered paid unless any check, draft, or other instrument of payment (given as premium) is paid in accordance with its terms. All premium checks must be made payable to Fidelity Life Association. **Do not make checks payable to the Agent. Do not leave the payee blank.**

**This Receipt is given on behalf of the Company.**

I have read and agree to the above terms.

\_\_\_\_\_  
Signature of Owner/Applicant

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Received from (name of payee)

\$ \_\_\_\_\_  
Amount

\_\_\_\_\_  
for coverage on the life of (show name of Proposed Insured)

\_\_\_\_\_  
Signature of licensed Agent

\_\_\_\_\_  
Dated