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

Application for Graded Death Benefit Life Insurance

Fidelity Life Association, A Legal Reserve Life Insurance Company

FIDELITYLIFE
Established 1896

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 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, 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 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 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

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:_______________