

Employer Name: _____		Proposal/Quote Number: _____			
Medical Indemnity Coverage Application		Date Quoted: _____			
Plan Selected:	<input type="checkbox"/> SILVER	<input type="checkbox"/> GOLD	<input type="checkbox"/> PLATINUM	<input type="checkbox"/> BRONZE	Policy Number: LM-100
Legal Name of Employer (include d/b/a):					
Business Address:	(Street)	(City)	(State)	(Zip Code)	
Mailing Address: (if other than above):	(Street)	(City)	(State)	(Zip Code)	
Contact Person & Title:			Email:		
Telephone Number:			Fax Number:		
<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Other (Specify)		
Eligible Class of Employees (check all that apply):		<input type="checkbox"/> Management Only	<input type="checkbox"/> Salaried	<input type="checkbox"/> Hourly	<input type="checkbox"/> All Full-time
If any subsidiary, affiliated company or division is to be insured or any employees are working at a location other than the address above, please explain:					
SIC Code:		Nature of Business:			
FEIN Number:		Years in Business (under Legal Name):			
Do your Employees, or any classification of Employees, have Group Coverage under another carrier?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", will this insurance replace it? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Current Insurer's Name and Telephone Number:					
(enclose copy of current carrier billing and policy #)					
Classes of Employees eligible for Coverage: All:			Other:		
Minimum Hourly Requirement per Week:		Number of Employees Working the Required Minimum Hours:			
Number of Employees Electing Coverage:			Number of Employees Waiving Coverage:		
Number of Employees and Dependents currently totally disabled:					
Number of Persons on COBRA or State Continuation:		Employees:		Dependents:	
Provide Names, Qualifying Events and Start Dates:					
PLAN SELECTION AND EFFECTIVE DATE.					
<input type="checkbox"/> RX : Employee <input type="checkbox"/> Dependents <input type="checkbox"/>					
<input type="checkbox"/> Dental: Employee <input type="checkbox"/> Dependents <input type="checkbox"/>			Prior Dental Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Supplemental Term Life Insurance: (Includes Accidental Death and Dismemberment for Employee Only)	Option 1 <input type="checkbox"/>	\$10,000 Employee	Option 1 <input type="checkbox"/>	\$ 5,000 Employee	
		\$ 5,000 Spouse		\$ 2,500 Spouse	
		\$ 2,500 Child(ren)		\$ 1,500 Child(ren)	
Complete Reverse Side					
FIDELITY SECURITY LIFE INSURANCE COMPANY					
Kansas City, Missouri 64111					

<input type="checkbox"/> Vision: Employee <input type="checkbox"/> Dependents <input type="checkbox"/>			
<input type="checkbox"/> Weekly Disability Income Benefit:		Weekly Benefit Amount: \$ _____ (up to the lesser of 66 2/3% of weekly base pay)	
		Maximum Benefit Period: <input type="checkbox"/> 13 Weeks <input type="checkbox"/> 26 Weeks	
		Elimination Period: <input type="checkbox"/> 0 Days <input type="checkbox"/> 8 Days <input type="checkbox"/> 15 Days	
Maternity Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer Contribution:	Medical Indemnity:	Employee %	Dependent %
	RX Benefit (must be the same as medical %)	Employee %	Dependent %
	Dental Insurance:	Employee %	Dependent %
	Vision Insurance:	Employee %	Dependent %
	Weekly Disability Income Benefit:	Employee %	
	Supplemental Term Life Insurance:	Employee %	Dependent %
	Accidental Death and Dismemberment:	Employee %	Dependent %
Employer must contribute a minimum of 50% toward the Employee's Weekly Disability Income Insurance			
Waiting Period for New/Existing Employees (check one): <input type="checkbox"/> None <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> Other			
		Waive Waiting Period for Current Employees: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Open Enrollment Period from		to	
Requested Effective Date: 12:01 A.M. on the 1 st day of			20
Do not terminate existing coverage until you have received confirmation of coverage from the Company!			

Agreement Section

We understand, and our agent has explained, the limitations and exclusions, including the pre-existing condition limitations.

We agree to contribute a minimum of _____% toward the Employee's premium and _____% toward the Dependent premium.

All statements made herein are complete and true and I understand that Fidelity Security Life Insurance Company (FSL) will rely on these statements and this information as the basis for approving this application.

It is further understood that no insurance will become effective without the approval of FSL. Do not cancel other coverage (if any) until notified by FSL of acceptance of this application. It is agreed that coverage for an Employee not actively at work at his or her usual place of employment on the day his or her insurance would otherwise become effective, will not become effective until the day following the date he/she returns to active employment. Insurance for any eligible person will not become effective if such person is hospital confined or unable to perform his/her Regular and Customary Activities. Such person's insurance will not become effective until the 1st of the month following the date of hospital discharge and on which he/she engages in his/her Regular and Customary Activities. No person's insurance will become effective before the Employee's insurance is effective.

We agree to make any necessary payroll deductions for any Employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. We request that the Administrator bill our share of the premiums due under any insurance policy issued.

We understand that the Policyholder may terminate the Policy by providing written notice to the Company at least 31 days prior to termination. The Company may terminate the Policy on the first day of any month on or after the first Policy Anniversary Date by providing written notice to the Policyholder at least 31 days prior to termination. The Policyholder is responsible for notifying the Insured of the termination or non-renewal of the Policy.

We understand that the Company and the Policyholder may agree to amend the Policy at any time without the consent of any Employee or other person.

We hereby represent that the information herein is true and complete and that I have read and understand this form.

We understand that existing coverage should not be canceled until notified in writing that this Application is accepted by FSL.

The undersigned acknowledges and understands that any misrepresentation on this Application by him or her or any of their agents or Employees may result in the cancellation or rescission of any Policy issued based on this Application.

I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this application for the Policyholder's state of domicile.

Make check payable to Fidelity Security Life Insurance Company

_____	_____
Printed or Typed Name of Officer, Owner, or Partner	Title
_____	_____
Signature of Officer, Owner, or Partner	Date

PRODUCER'S INFORMATION

Writing Producer			
Producer Agent Number: _____			
Name: _____		Address: _____	
Tax ID Number: _____	Social Security Number: _____	Phone Number: () _____	
• Do you have a broker license?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Commission Paid to: _____	
Licensed with Fidelity Security Life Insurance Company in the state where this Employer is located on _____			
(date)			
• If "Yes", please submit copy			

General Agent			
General Agent Number: _____			
Name: _____		Address: _____	
Tax ID Number: _____	Social Security Number: _____	Phone Number: () _____	
• Do you have a broker license?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Commission Paid to: _____	
Licensed with Fidelity Security Life Insurance Company in the state where this Employer is located on _____			
(date)			
• If "Yes", please submit copy			

PRODUCER'S STATEMENT

All statements in the Group Application are true and complete. I understand that I represent the interest of the Applicant firm for insurance, not the Insurance Company, nor the Administrator. I have advised the Applicant firm not to cancel any existing coverage unless and until notified in writing. I understand that I have no right to bind this coverage or alter the terms of the Policy in any matter. All Policy limitations and exclusions, including pre-existing condition limitations, have been explained to the Applicant firm.

Producer's Signature	Date	Print Producer's Name
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FRAUD WARNING NOTICE

For residents of all states (except the following)}	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
Arkansas	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Maine	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Nebraska	Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
Pennsylvania	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.
Tennessee	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.