

IAC PERSONAL HEALTH PLANS BENEFIT SELECTION FORM
Underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri

CASE NUMBER _____

APPLICANT'S NAME _____
 (LAST) (FIRST) (INITIAL)

SOCIAL SECURITY NUMBER _____

PLAN SELECTION: Design your plan by selecting your In-Network plan options. Out-of-Network benefits differ from In-Network benefits and are based on your selections below. See the product brochure for details.

<input type="checkbox"/> Deluxe Plan <input type="checkbox"/> <u>No Copay</u> <u>Deductible:</u> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$5,500 <u>Maximum out-of-pocket options:</u> <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000 <u>Rx Options</u> <input type="checkbox"/> Discount Only <input type="checkbox"/> Rx Copay <input type="checkbox"/> Ded & Coins	<input type="checkbox"/> Advantage Plan <input type="checkbox"/> <u>No Copay</u> <u>Deductible:</u> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <u>Rx Options</u> <input type="checkbox"/> Discount Only <input type="checkbox"/> Rx Copay <input type="checkbox"/> Ded & Coins	<input type="checkbox"/> Value Plan <u>Deductible:</u> <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$5,500 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <u>Rx Options</u> <input type="checkbox"/> Discount Only <input type="checkbox"/> Rx Copay <input type="checkbox"/> Ded & Coins	<input type="checkbox"/> High Deductible Plan <u>Deductible:</u> Single Family <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$2,700 <input type="checkbox"/> \$5,450 <input type="checkbox"/> \$3,000* <input type="checkbox"/> \$6,000* <input type="checkbox"/> \$4,000* <input type="checkbox"/> \$8,000* <input type="checkbox"/> \$5,250* <input type="checkbox"/> \$10,500* *Available only if 100% Coinsurance Option is selected. <u>Coinsurance Options:</u> <input type="checkbox"/> 100% <input type="checkbox"/> 80% <u>HSA Enhancement</u> <input type="checkbox"/> IAC's HSA <input type="checkbox"/> Own HSA (<i>Submit attestation of HSA form</i>) <input type="checkbox"/> No HSA <u>Rx Options</u> <input type="checkbox"/> Discount Only <input type="checkbox"/> Deductible & Coinsurance	<input type="checkbox"/> Daily Plan <u>Daily Deductible</u> <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <u>Rx Options</u> <input type="checkbox"/> Discount Only <input type="checkbox"/> Rx Copay
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Preferred Provider Organization (PPO) Network Selected: _____

Optional Benefits

18-Month Rate Guarantee	<input type="checkbox"/> Yes <input type="checkbox"/> No (12-Month Rate Guarantee will apply if not elected)
Wellness Coverage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Texas Mandated Wellness only
Supplemental Accident	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
Vision Coverage <i>Available only in CO, IL, MO, NE, NV, NM, OH, OK, TN, VA, & WV</i>	<input type="checkbox"/> Option 1- \$10 Exams / \$25 Lenses <input type="checkbox"/> Option 2- \$20 Exams / \$20 Lenses
24-hour Occupational Coverage <i>Automatically included in FL</i>	Sole proprietors, partners (ownership over 10%), or business owners not covered by Workers' Compensation are eligible. Do you qualify for this benefit? (Verification may be necessary.) Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No

Life Insurance - Life insurance is not available in FL, OH, OK, or TX.
 Yes: \$10,000 Minimum
 Other: List amount in \$10,000 increments, up to \$100,000 \$ _____
 No

Dependent Life Insurance Yes No

BENEFICIARY: _____

RELATIONSHIP: _____

Attach this form to your Fidelity Security Life Insurance Company Application for Insurance

Case Number	Enter	Date	For Administrative Use Only	Date	Eff Date	PCEFD	Other:
			Approved By				

FIDELITY SECURITY LIFE INSURANCE COMPANY

APPLICATION FOR INSURANCE

Underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri

CASE NUMBER _____

ATTENTION PRODUCER: Where do you want the Certificate of Coverage mailed? (Check one) Producer _____ Insured _____

GENERAL INFORMATION

Applicant Information (Please print in blue or black ink)

Applicant's Name _____ (Last) (First) (Initial)			Social Security Number _____		
Applicant's Home Address _____ Street City State Zip Code					
Billing Address _____ Street City State Zip Code				E-MAIL ADDRESS _____	
Home Telephone Number _____		Work Telephone Number _____		Fax Number _____	Best Time For Us To Call (Hm) _____ (Wk) _____
Occupation (Title & Industry) _____ Title Industry		Status: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married		Birthdate ____/____/____	Age ____
				Height ____ Ft ____ In	Weight ____ Lbs

Dependent Information (Complete only for dependents to be covered under this plan)

Spouse's Name _____ (Last) (First) (Initial)			Social Security Number _____			
Spouse's Occupation (Title & Industry) _____		Height ____ Ft ____ In	Weight ____ Lbs	Birthdate ____/____/____	Age ____	
Dependent's Name (First and Last)	Relationship	Sex	Birthdate	Height	Weight	Full-time Student?
_____	_____	_____	____/____/____	____ Ft ____ In	____ Lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____	____ Ft ____ In	____ Lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____	____ Ft ____ In	____ Lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____	____ Ft ____ In	____ Lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____	____ Ft ____ In	____ Lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____	____ Ft ____ In	____ Lbs	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has the Applicant or Spouse (if applying for coverage) used tobacco or tobacco cessation products during the past 12 months?

Applicant: No Yes – indicate types of tobacco/cessation products and the frequency of usage: _____

Spouse: No Yes – indicate types of tobacco/cessation products and the frequency of usage: _____

Requested Effective Date (check one):

I request the Company assign my effective date to be the 1st of the month following approval.

I request an effective date of _____ (must be the 1st or 15th of the month). I understand I cannot change this date.

If the Company is unable to approve the application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

Mode of Payment: Direct Bill: Select Monthly Quarterly or Semi-annually. Submit check for first premium payment with this application.

Credit Card* Bank Draft* Monthly List Bill

*Drawn monthly only. Complete the IAC Monthly Automatic Payment Plan page.

Who is to be insured? (Check all that apply) Applicant Spouse Child(ren)

Other Coverage (Must be completed for the application to be processed.)

Are you or any dependents replacing other health insurance coverage? Yes No If yes, please provide the following information:

Carrier Name: _____ Policy No. _____ Effec. Date: _____ Termination Date: _____

Was this an employer-sponsored group health plan? Yes No

Is it your intent to be considered under HIPAA provisions? Yes No If yes, you must complete the HIPAA eligibility section of this application and attach the Certificate of Creditable Coverage you have received from your Employer.

PREFERRED UNDERWRITING CLASSIFICATION

INSTRUCTIONS: You may qualify for a Preferred Rating Classification depending on your health history and risk-avoidance behavior. Any applicants applying for coverage with the intent to obtain a Preferred Rate:

- a. Must be the proposed primary insured and/or spouse. Preferred Rates are not available for dependent children;
- b. Must be age 18 or older, but not older than age 50;
- c. Must not have a condition that would result in a health exclusion rider or health rate-up at any level of benefit for the plan; and
- d. Must answer "No" to questions 1-7 below. If age 40 or older, must also answer "Yes" to question 8 and provide the requested information.

The following questions must be answered by each person proposed for insurance (Proposed Insured and the Proposed Insured's spouse, if applicable) to determine his or her eligibility for Preferred Rates.

Primary Applicant	Spouse	Question																																																																																								
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you been advised by a medical professional that you have blood pressure in excess of 130/85 (more than 130 systolic and/or more than 85 diastolic) or have you been treated for high blood pressure within the past 12 months?																																																																																								
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Have you been advised by a medical professional that you have a total cholesterol reading above 200 or have you been treated for elevated cholesterol or triglycerides within the past 12 months?																																																																																								
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you had any convictions for DUI or DWI or have you had more than 2 moving violations within the past 2 years?																																																																																								
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you used tobacco in any form or any nicotine products at any time during the past 2 years?																																																																																								
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Are you currently outside the weight range shown on the Build Chart for Preferred Risks?																																																																																								
		<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4">Male</th> <th colspan="4">Female</th> </tr> <tr> <th>Height</th> <th>Weight</th> <th>Height</th> <th>Weight</th> <th>Height</th> <th>Weight</th> <th>Height</th> <th>Weight</th> </tr> </thead> <tbody> <tr> <td>5'0"</td> <td>105-152</td> <td>5'9"</td> <td>131-191</td> <td>4'10"</td> <td>90-128</td> <td>5'7"</td> <td>112-160</td> </tr> <tr> <td>5'1"</td> <td>110-155</td> <td>5'10"</td> <td>134-197</td> <td>4'11"</td> <td>92-130</td> <td>5'8"</td> <td>115-165</td> </tr> <tr> <td>5'2"</td> <td>113-159</td> <td>5'11"</td> <td>138-203</td> <td>5'0"</td> <td>94-133</td> <td>5'9"</td> <td>118-172</td> </tr> <tr> <td>5'3"</td> <td>115-162</td> <td>6'0"</td> <td>142-208</td> <td>5'1"</td> <td>96-136</td> <td>5'10"</td> <td>122-178</td> </tr> <tr> <td>5'4"</td> <td>117-166</td> <td>6'1"</td> <td>147-215</td> <td>5'2"</td> <td>98-140</td> <td>5'11"</td> <td>125-183</td> </tr> <tr> <td>5'5"</td> <td>120-171</td> <td>6'2"</td> <td>153-220</td> <td>5'3"</td> <td>101-143</td> <td>6'0"</td> <td>129-188</td> </tr> <tr> <td>5'6"</td> <td>122-175</td> <td>6'3"</td> <td>158-226</td> <td>5'4"</td> <td>104-147</td> <td>6'1"</td> <td>132-192</td> </tr> <tr> <td>5'7"</td> <td>125-181</td> <td>6'4"</td> <td>163-232</td> <td>5'5"</td> <td>107-151</td> <td>6'2"</td> <td>135-198</td> </tr> <tr> <td>5'8"</td> <td>128-186</td> <td>6'5"</td> <td>169-240</td> <td>5'6"</td> <td>109-156</td> <td>6'3"</td> <td>138-204</td> </tr> </tbody> </table>	Male				Female				Height	Weight	Height	Weight	Height	Weight	Height	Weight	5'0"	105-152	5'9"	131-191	4'10"	90-128	5'7"	112-160	5'1"	110-155	5'10"	134-197	4'11"	92-130	5'8"	115-165	5'2"	113-159	5'11"	138-203	5'0"	94-133	5'9"	118-172	5'3"	115-162	6'0"	142-208	5'1"	96-136	5'10"	122-178	5'4"	117-166	6'1"	147-215	5'2"	98-140	5'11"	125-183	5'5"	120-171	6'2"	153-220	5'3"	101-143	6'0"	129-188	5'6"	122-175	6'3"	158-226	5'4"	104-147	6'1"	132-192	5'7"	125-181	6'4"	163-232	5'5"	107-151	6'2"	135-198	5'8"	128-186	6'5"	169-240	5'6"	109-156	6'3"	138-204
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Are you currently taking any prescription medication other than those used for acute medical conditions such as antibiotics or for those used for non-medical conditions such as birth-control?																																																																																								
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Has it been more than 90 days since you had major medical coverage (group or individual) in force?																																																																																								
<input type="checkbox"/> Under age 40 <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Under age 40 <input type="checkbox"/> Yes <input type="checkbox"/> No	8. If age 40 or older, have you had a physical exam by a licensed physician that included an evaluation of your build, blood pressure, and cholesterol in the past 3 years?																																																																																								
		<table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 33%; border-bottom: 1px solid black;"></td> <td style="border: none; width: 33%; border-bottom: 1px solid black;"></td> <td style="border: none; width: 33%; border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border: none; text-align: center;">Physician Name</td> <td style="border: none; text-align: center;">Physician Address</td> <td style="border: none; text-align: center;">Date of Exam</td> </tr> </table>				Physician Name	Physician Address	Date of Exam																																																																																		
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Note: Information we gather during the application process about medical conditions, avocations, or medications you are taking **may** prevent you from qualifying for preferred rates.

My answers are true and complete. I represent that to the best of my knowledge and belief all of the statements and answers on this questionnaire are complete and true. I understand that the information provided herein along with the application and any amendments will be the basis for this contract. I understand and agree that this questionnaire is a part of the application for health/medical insurance coverage with Fidelity Security Life Insurance Company.

I attest that the information provided above is true, complete and correct		
Name of Applicant or parent, if applicant is under age 18 (print)	Name of Spouse if applying for coverage (print)	Date
Signature of Applicant or parent, if applicant is under age 18	Signature of Spouse if applying for coverage	Date
Name of licensed producer	Signature of licensed producer	Date

EVIDENCE OF INSURABILITY

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and provide details in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Have you or any of your eligible dependents received disability benefits? If yes, list names and type of coverage:
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Has any person to be insured ever been diagnosed or tested positive for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a Physician or member of the medical profession? If yes, list names:
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Has anyone to be insured had breast implants, pin, plate, or other implants? If yes, list names and provide details on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Have you had any convictions for reckless driving or driving under the influence of alcohol or drugs? If yes, list name, violation(s) and date(s) of occurrence in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. In the past 5 years, have you or any eligible dependent engaged in, or plan to engage in, any hazardous sport including, but not limited to: scuba diving, rodeo activities, skydiving or auto, motorcycle or motor boat racing? If yes, please explain on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Are you, your spouse, or any dependents now pregnant or an expectant parent, whether applying for coverage or not? If yes, list names and provide details in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Are you or your dependents currently taking or have you been prescribed medications within the past 12 months? List details/medications on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Have you or your dependents previously applied for coverage with Insurers Administrative Corporation? If yes, list the policy number:
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Have you or your dependents been hospitalized within the last 7 years? If yes, list names and provide details on the following page.

12. Within the past seven years, has any person to be insured had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Abnormal Test Results			Eye Disorders			Neurological Disease		
Alcoholism/Alcohol Abuse			Fractures/Dislocations			Pap Smear, Abnormal		
Allergies			Gallbladder Disorder			Paralysis		
Arthritis or Rheumatism			Headaches/Migraine			Prostate/Rectal Disorder		
Asthma/Respiratory Disorder			Heart Disorder/Murmur/Heart Attack/Coronary Artery Disease			Reproductive Organs Disorder/Endometriosis		
Back/Muscle or Joint Disorder			Hepatitis: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>			Sexually Transmitted Diseases		
Bladder Disorder			Hernia			Sinus Disorder		
Blood Disorder/Hemophilia			High Blood Pressure/Hypertension			Skin Disorder		
Bone Disease/Deformity			High Cholesterol			Sleep Disorders		
Breast Disorder/Fibrocystic Breast Disease			Infertility Testing/Treatment			Spinal Disorder/Back/Neck Strain		
Cancer			Kidney Disorder			Stroke		
Colitis, Spastic Colon, Polyps			Liver Disorder			Thyroid or Goiter		
Congenital Disorder			Lupus/Systemic or Discoid			Transplants		
Cystic Fibrosis			Lymphadenopathy/Immune Disorder			Tuberculosis		
Diabetes/Pancreatic Disorders			Menstrual Disorder			Tumors/Cysts/Polyps/Growths		
Digestive Disorder/Reflux			Mental, Nervous, Emotional Disorder / Anxiety/Depression/Attention Deficit Disorder			Ulcerative Colitis/Crohn's/ Regional Ileitis		
Drug Addiction			Mental Retardation			Ulcers		
Ear/Throat Disorders			Down's Syndrome			Urinary Tract Disorder		
Eating Disorder/Anorexia/ Bulimia			Muscular Dystrophy			Vascular Disorder		
Emphysema/Lung Disorder/COPD			Cerebral Palsy			Other conditions		
Epilepsy and/or Seizure			Brain or Nerve Disorder					

If you answered yes to any of the above conditions, list the condition and provide details in the Health History section on the following page.

I attest that the information provided above is true, complete and correct

Name of Applicant or parent, if applicant is under age 18 (print)

Name of Spouse if applying for coverage (print)

Date

Signature of Applicant or parent, if applicant is under age 18

Signature of Spouse if applying for coverage

Date

HEALTH HISTORY

INSTRUCTIONS: Provide complete details to any question marked "Yes" in the Evidence of Insurability section in the space provided below. We may need to request additional information regarding your health history from you or your attending physician. If you need more space, please use the Health History Supplementary Form located at the end of this application.

Question #	Person's Name	Condition(s) & Treatment	Date of Onset and Last Office Visit Mo./Yr.	Recovery Date Mo./Yr.	Complete Names and Addresses of Physicians & Hospitals
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	

LAST PHYSICIAN SEEN

INSTRUCTIONS: List your healthcare providers for the past 7 years in the space provided below.

Physician's Name	Full Address	Phone Number	Who was treated	Date of visit	Reason
				____/____	
				____/____	
				____/____	
				____/____	
				____/____	

MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED

INSTRUCTIONS: List all medications prescribed or taken by you or your dependents currently and in the past 12 months.

Person's Name	Medications	Frequency & Dosage	Length of time on medication	Date medication was last taken	Complete Names and Addresses of Physicians
				____/____	
				____/____	
				____/____	
				____/____	
				____/____	

I attest that the information provided above is true, complete and correct

Name of Applicant or parent, if applicant is under age 18 (print)

Name of Spouse if applying for coverage (print)

Date

Signature of Applicant or parent, if applicant is under age 18

Signature of Spouse if applying for coverage

Date

HIPAA ELIGIBILITY *If you are applying for HIPAA coverage, provide a copy of your Certificate of Creditable Coverage.

INSTRUCTIONS: This section must be completed if anyone applying for coverage is electing coverage under HIPAA provisions. If you reside in a state that offers coverage under a risk pool arrangement, please ask your producer about your risk pool coverage options.

Who is applying for HIPAA eligibility? <input type="checkbox"/> Primary Applicant <input type="checkbox"/> Spouse		<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse
Have you been continuously covered by health insurance (the last of which is a group health plan) for a minimum of eighteen months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What was the reason the coverage terminated under the most recent health insurance plan:	Was it for non-payment of premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Was it for fraud?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there a break in health insurance coverage in excess of 62 days during the past 18 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you eligible for or do you currently have group health insurance through your employer, your spouse's employer or as a dependent on any person's plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently eligible for coverage under any of the following: COBRA, State Continuation, Federal Employee's Continuation, MEDICARE or MEDICAID?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was your most recent coverage under COBRA or any State or Federal Continuation plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "yes," when did coverage begin _____ and when will coverage be exhausted under such plan _____?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was your current coverage a conversion plan elected through your previous carrier?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

AGREEMENT & SIGNATURE

INSTRUCTIONS: Read the following information and signify your agreement with the terms of this agreement for insurance by signing and dating the application as indicated below.

Premium Payment: I understand and agree that I am responsible for making the proper monthly premium payments. Furthermore, it is understood that a grace period of thirty-one (31) days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the thirty-one (31) days grace period, coverage for all insured persons shall lapse as of the premium due date. Any negotiable premium checks received in an envelope postmarked after the thirty-one day grace period will be refunded less any amounts due (if any) from previous months. I understand there is a one-time, non-refundable application fee.

Pre-certification and Signature: I understand that failure to pre-certify treatment results in reduced benefits pursuant to the terms of the master policy.

U.S. Resident: I understand that the coverage under this plan is available for United States residents and benefits are not payable for medical expenses outside of the United States except when traveling, not to exceed 90 days.

Not an employer sponsored health plan: I understand and agree that this medical plan is not intended to be an employer sponsored health plan. I certify the premiums are being paid by me as a personal expense and neither my employer nor the employer of my dependents are paying any part of the premium either directly or through wage adjustments or otherwise and b.) to my knowledge, my employer will not treat or represent this health plan as an employer health insurance plan for any purpose, including a business tax deduction.

Application for group plan membership: I understand that I am applying as an individual for membership to the Multiple Unit Security Trust II and am simultaneously applying for insurance to which I am now or may become eligible for under the provisions of the Group Master Policy issued to that trust by Fidelity Security Life Insurance Company. I understand that my application is subject to medical underwriting and approval by Fidelity Security Life Insurance Company or its authorized Administrator in accordance with the underwriting guidelines in effect. I understand that acceptance of the check submitted with the application does not constitute approval or guarantee of coverage.

My answers are true and complete: I have personally reviewed all of my answers to the questions on this application and certify that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I certify I have fully understood the questions asked. I understand that any misstatements or failure to report information may be used as the basis of rescission of coverage for me or my dependents, if any. I understand that under no circumstances is any agent allowed to: a.) waive, alter or modify any questions; b.) permit me to inaccurately answer any question; or c.) instruct me not to disclose any particular medical condition on the application. I understand that no agent is authorized or has the authority to alter the terms of the Group Master Policy.

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

Dated at _____ on the _____ day of _____, 20____.
 City State Month Year

 Name of Applicant or parent, if applicant is under age 18 (print) Name of Spouse if applying for coverage (print) Date

 Signature of Applicant (or parent, if applicant is under age 18) Date Signature of Spouse (if applying for coverage) Date

IAC'S MONTHLY AUTOMATIC PAYMENT PLAN

To initiate the Automatic Payment Plan, the following must accompany your application:

- Credit Card Information; - OR -
- A voided check OR savings account deposit slip (business accounts not acceptable);
- This portion of the application must be fully completed and signed;
- A personal check made payable to Insurers Administrative Corporation for the initial premium. (Not required for Credit Card option.)

Coverage purchased by check is subject to clearance of the check, and coverage purchased by credit card is subject to acceptance of the credit card issuer.

Credit Card Payment Initial Amount \$ _____

Choose one: MasterCard Visa Name (as it appears on card) _____

Card# _____ Exp.Date ____/____/____

Signature of Cardholder _____

Monthly Bank Draft

Fidelity Security Life Insurance Company (FSL) or its authorized Administrator, Insurers Administrative Corporation (IAC), is hereby authorized to debit my checking or savings account on the first business day of each month until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued.

I further authorize the bank named below to pay and charge to my account those payments that are drawn on my account by FSL, and I agree that the bank named below shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify IAC in writing.

Signature of primary payer (or depositor if different) _____

Date ____/____/____

Name (please print) _____ Relationship to Applicant _____

Name of Bank _____ Address _____

Bank Routing Number _____

Checking Account No. _____ Savings Account No. _____

PRODUCER / GENERAL AGENT INFORMATION

AGENT INFORMATION	%	AGENT 2 INFORMATION (IF COMMISSIONS ARE TO BE SPLIT)	%
Producer's Name _____		Producer's Name _____	
Company Name _____		Company Name _____	
IAC Producer # _____		IAC Producer # _____	
Are you licensed in the state where the application was completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you licensed in the state where the application was completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address _____ <small>Street City State Zip</small>		Address _____ <small>Street City State Zip</small>	
Business Phone _____ Fax _____		Business Phone _____ Fax _____	
E-Mail Address _____		E-Mail Address _____	
PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Fidelity Security Life Insurance Company.		PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Fidelity Security Life Insurance Company.	

Producer's Signature _____ Date _____ Producer's Signature _____ Date _____

General Agent's Name: _____ General Agent's IAC # _____

General Agent's Phone _____ General Agent's Fax _____ General Agent's E-Mail _____

_____ Date Application Sent to General Agent _____ Date Application Received by General Agent _____ Date Application Sent to IAC _____

PRODUCER'S FINAL CHECKLIST

- | | |
|--|--|
| <ul style="list-style-type: none"> ✓ Are all the questions answered and boxes checked? ✓ Has the applicant (and spouse, if applying) signed <i>both</i> Medical and Agreement on the application? ✓ Have you obtained a personal check from the applicant payable to Insurers Administrative Corporation? | <ul style="list-style-type: none"> ✓ Have you offered the applicant the option of the Monthly Automatic Payment Plan? ✓ Has the applicant enclosed a voided check for the Monthly Automatic Payment Plan, if applicable? |
|--|--|

Submit to **Insurers Administrative Corporation**
P.O. Box 37457, Phoenix, AZ 85069-7457
 Fax No. (602) 861-6068

Authorization for Release of Health-Related Information.

I authorize the disclosure of health information regarding, or related to the following individuals for whom an application for insurance has been submitted:

Print Name(s): (Last)	(First)	(MI)	Date of Birth (Month/Day/Year)
1			
2			
3			
4			
5			
6			

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Fidelity Security Life Insurance Company ("FSL"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit FSL, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, including whether the individual is subject to a pre-existing condition exclusion.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to P.O. Box 37587, Phoenix, AZ 85069, Attention Privacy Officer.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative: _____ Date: _____
X _____
X _____
X _____

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual:

Name: _____ Authority: _____

HEALTH HISTORY SUPPLEMENTAL FORM

INSTRUCTIONS: Provide complete details to any question marked "Yes" in the Evidence of Insurability section in the space provided below. We may need to request additional information regarding your health history from you or your attending physician. Attach as many of these Health History Supplemental Forms as necessary to provide complete information.

Question #	Person's Name	Condition(s) & Treatment	Date of Onset and Last Office Visit Mo./Yr.	Recovery Date Mo./Yr.	Complete Names and Addresses of Physicians & Hospitals
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	
			____/____	____/____	

LAST PHYSICIAN SEEN

INSTRUCTIONS: List your healthcare providers for the past 7 years in the space provided below.

Physician's Name	Full Address	Phone Number	Who was treated	Date of visit	Reason
				____/____	
				____/____	
				____/____	
				____/____	
				____/____	

MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED

INSTRUCTIONS: List all medications prescribed or taken by you or your dependents currently and in the past 12 months.

Person's Name	Medications	Frequency & Dosage	Length of time on medication	Date medication was last taken	Complete Names and Addresses of Physicians
				____/____	
				____/____	
				____/____	
				____/____	
				____/____	

I attest that the information provided above is true, complete and correct

 Name of Applicant or parent, if applicant is under age 18 (print) Name of Spouse if applying for coverage (print) Date

 Signature of Applicant or parent, if applicant is under age 18 Signature of Spouse if applying for coverage Date