☐ New Contract
☐ Contract Change For #_____
☐ Reinstatement For #_____

Group Enrollment Form
Fidelity Life Association ("the Company")
Administrative Office: P.O. Box 506, Keene, N.H. 03431-0506

FIDELITYLIFE
Established 1896

I. Employee/Payor Information

Group Name_____ Location/Dept. _____
Name _____ Date of Hire _____Home Phone _____
Legal Address _____Email_____
Street City State Zip
Annual Salary _____Social Security # _____Employee ID _____
Is the employee actively at work performing the regular duties of the job in the usual manner and the usual place of employment? ☐ Yes ☐No

II. Proposed Insured Information

	Name	Gender	Birth Date	Age	Tobacco or Nicotine Products in Last 12 Months?
1. Employee/Payor:	_____	☐ M ☐F	_____	____	☐ Yes ☐No
2. Spouse:	_____	☐ M ☐F	_____	____	☐ Yes ☐No
3. Child 1:	_____	☐ M ☐F	_____	____	☐ Yes ☐No
4. Child 2:	_____	☐ M ☐F	_____	____	☐ Yes ☐No

III. Coverage Information **Planned Premium Mode: ☐Weekly ☐Bi- Weekly ☐Monthly ☐Other_____**

Base Plan: Lifetime Benefit Term (LBT)
Employee/Payor Face _____ Premium $_____
Is the Proposed Insured a U.S. Citizen or a permanent resident?
☐ Yes ☐No

Level Term Optional Benefit:

1. Employee/Payor: Face _____ Premium $_____
2. Spouse: Face _____ Premium $_____
3. Child 1: Face _____ Premium $_____
4. Child 2: Face _____ Premium $_____

Optional Benefits
Employee/Payor:

☐ Waiver Premium $_____
☐ Dependent Child Benefit: ____Units Premium $_____
☐ Accidental Death Benefit Premium $_____
☐ LTC Premium $_____
☐ LTC/TI Combo Premium $_____
☐ EOB Premium $_____
☐ Guaranteed Insurance Option
☐ Other _____ Premium $_____
Total Planned Premium $_____

Base Plan: Lifetime Benefit Term (LBT)
Spouse Face _____ Premium $_____
Is the Proposed Insured a U.S. Citizen or a permanent resident?
☐ Yes ☐No

Level Term Optional Benefit:

1. Employee/Payor: Face _____ Premium $_____
2. Spouse: Face _____ Premium $_____
3. Child 1: Face _____ Premium $_____
4. Child 2: Face _____ Premium $_____

Spouse:

☐ Payor Waiver Premium $_____
☐ Dependent Child Benefit: ____Units Premium $_____
☐ Accidental Death Benefit Premium $_____
☐ LTC Premium $_____
☐ LTC/TI Combo Premium $_____
☐ EOB Premium $_____
☐ Guaranteed Insurance Option
☐ Other _____ Premium $_____
Total Planned Premium $_____

IV. Beneficiary

The Employee/Payor will be the Beneficiary of any coverage issued on a Spouse or Child, unless otherwise stated in this section. The Spouse will be the Beneficiary of any coverage issued on the Employee/Payor, unless otherwise stated in this section.

Insured: _____ Beneficiary: _____ Relationship: _____
Insured: _____ Beneficiary: _____ Relationship: _____

V. Certificate Holder

The Employee/Payor will be the Certificate Holder unless another is subsequently designated.

VI. Conditional Issue Questions: Please answer all required questions for any Person proposed for Coverage. If any question is answered "Yes" for any proposed insured, please answer all of the Simplified Eligibility questions on Page 2 for that Person.

Proposed Insured Person:	Employee		Spouse		Child 1		Child 2	
	Yes	No	Yes	No	Yes	No	Yes	No
a. Has the Employee/Payor missed more than 5 days of active work due to an illness or injury in the past 3 months?	☐	☐	N/A		N/A		N/A	
b. Has any Proposed Insured been treated in a medical facility, hospitalized or disabled in the past 6 months? Hospitalized means in-patient or outpatient, whether or not confined.	☐	☐	☐	☐	☐	☐	☐	☐
c. Has any Proposed Insured, within the last 10 years, been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐	☐	☐	☐	☐
d. Has any Spouse or Child proposed for coverage been seen or treated by a licensed physician or other medical practitioner within the past 6 months?	☐	☐	☐	☐	☐	☐	☐	☐

VII. Other Coverage: Does any Person proposed for coverage have any life insurance in force or is any application for life insurance or reinstatement now pending? ☐ No ☐ Yes If Yes, complete the following:

Insured	Name of Company	Face Amount	Month/Year Issued	To be Replaced?
				☐ Yes ☐ No
				☐ Yes ☐ No

VIII. Simplified Issue Questions:

1. Employee/Payor: Height: ___Ft. ___In. Weight_____lbs.
2. Spouse: Height: ___Ft. ___In. Weight_____lbs.
3. Child 1: Height: ___Ft. ___In. Weight_____lbs.
4. Child 2: Height: ___Ft. ___In. Weight_____lbs.

Within the past 5 years, has any Person proposed for insurance been admitted or advised to be admitted to a hospital or received medical advice or treatment for:	Proposed Insured Person: Employee Yes	Employee No	Spouse Yes	Spouse No	Child 1 Yes	Child 1 No	Child 2 Yes	Child 2 No
a. any chest pain, heart disease, stroke or paralysis, lung or respiratory disease, blood disease or high blood pressure? If yes, provide most recent blood pressure reading and date: _____;	☐	☐	☐	☐	☐	☐	☐	☐
b. any cancer, tumor, disorder of the kidney, liver disease or hepatitis;	☐	☐	☐	☐	☐	☐	☐	☐
c. any mental or psychiatric disorder, stomach or intestinal disorder or reproductive organ disorder;	☐	☐	☐	☐	☐	☐	☐	☐
d. received or been advised to have, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance;	☐	☐	☐	☐	☐	☐	☐	☐
e. taken any prescription medication in the past 6 months (If "Yes", state name of medication, reason for taking, frequency and dosage.);	☐	☐	☐	☐	☐	☐	☐	☐
f. had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study, operation or treatment.	☐	☐	☐	☐	☐	☐	☐	☐
g. Other than stated above, within the past 5 years, had any other illness, operation or treatment?	☐	☐	☐	☐	☐	☐	☐	☐

Details: Provide full details of "yes" answers on Page 1 and 2. Include the diagnoses, date, duration, and names and address of all attending physicians and medical facilities.

Proposed Insured Person	Question #	Describe Injury, Illness, Disorder, Symptoms and Medication (include Dosage and frequency)	Date Diagnosed	Length of Treatment	Current Health Status	Name & Address of Doctor or Hospital

If more space is needed to provide details, attach a signed and dated additional sheet of paper.

Declaration, Agreement and Authorization To Release Information: I declare that each answer given to the questions contained in this enrollment form 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 part of this enrollment form. I also understand that the Company reserves the right to accept or deny this enrollment form after taking into account whatever information may be available to it, including availability as to coverage by its reinsurers. All statements and answers on this enrollment form are full, complete and true to the best knowledge and belief of each person who has signed below.

The insurance being applied for will be effective as of the enrollment form date, provided the person(s) to be insured is (are) found acceptable for such insurance as applied for.

I/We authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, MIB, Inc. or employer to give to Fidelity Life Association any information they might have regarding the diagnosis, treatment, prescription and prognosis of any physical or mental condition as applicable. To facilitate the rapid transmissions of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the Company 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 request for insurance or to evaluate a claim during the time that this authorization is valid. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization.

All or part of such information may be disclosed to a physician of my choosing, my insurance agent, MIB, Inc., to other persons or organizations performing business or legal services in connection with this enrollment form, including reinsuring companies as may be required by law.

The Certificate Holder/Insured and the agent certify that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery.

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 enrollment form for insurance may be guilty of a criminal offense under state law.

Agent: 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? (If Yes, complete appropriate State replacement forms)..... ☐ Yes ☐ No

SIGNED AT: *(State)* *DATE:* SIGNATURE OF LICENSED AGENT:

SIGNATURE OF Employee/Payor: PRINTED NAME OF AGENT:

SIGNATURE OF SPOUSE OR CHILD: (if required) STATE LICENSE NUMBER: (if required by law)

FIDELITYLIFE
Established 1896

Fidelity Life Association, A Legal Reserve Life Insurance Company
Administrative Office: P.O. Box 506
Keene, NH 03431-0506

Supplement to Group Enrollment Form

Insured Name: _____
Please Print

Applicant SSN: _____

This Supplement to the Group Enrollment Form for Life Insurance is requried to be completed when an applicant or spouse applies for the Optional Accelerated Benefit for Long Term Care

	Applicant		Spouse	
	Yes	No	Yes	No
1. Does the Applicant or Spouse have any other long term care insurance in force (including health care service contract, health maintenance organization contract)? *(If Yes, give details below.)*	☐	☐	☐	☐
2. Did the Applicant or Spouse have any long term care insurance policy or certificate lapse during the last 12 months? *(If Yes, provide date of Lapse:_____).*	☐	☐	☐	☐
3. Are you covered by Medicaid?	☐	☐	☐	☐
4. Do you intend to replace any of your medical or health insurance coverage with this Certificate? *(If Yes, give details below.)*	☐	☐	☐	☐

Applicant or Spouse	Name of Company	Face Amount	Month/Year Issued	To be Replaced?
				☐ Yes ☐ No
				☐ Yes ☐ No

SECONDARY ADDRESSEE:

As required by State law, an insurer issuing Long Term Care Coverage is required to notify the applicant of the right to designate at least one additional person to receive notification of a possible lapse or termination in coverage. Notice will be provided to any secondary addressee 30 days after a premium is due and unpaid. This constitutes our notification to you of your right to designate such an addressee. If you wish to designate a secondary addressee, please do so by complete the following:

Designation of Secondary Addressee:

Secondary Addressee *(Give Full Legal Name):*_____

Mailing Address: _____
Street City State Zip

_____ _____
Signature Date