

PROPOSED INSURED	Full Legal Name of the Proposed Insured: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Driver's License Number: _____ State of Issue: _____ <input type="checkbox"/> I do not have a driver's license (explain below)
Occupation & Employer: _____ Annual Income: \$ _____	

COVERAGE	Plan: <input type="checkbox"/> Graded Death Benefit Whole Life Automatic Premium Loan Option on GDB Whole Life? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Graded Death Benefit 10 Year Term <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Graded Death Benefit 20 Year Term
	<input type="checkbox"/> Graded Death Benefit 30 Year Term
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: _____	

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.	
QUESTIONS OF THE PROPOSED INSURED	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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Have you, within the past 2 (two) years:
	a. had a heart attack (myocardial infarction) or stroke (cerebral vascular accident)? <input type="checkbox"/> Yes <input type="checkbox"/> No
	b. had or are now awaiting an organ or bone marrow transplant (except as a donor)? <input type="checkbox"/> Yes <input type="checkbox"/> No
	c. been diagnosed with cancer, received or been prescribed radiation or chemo therapy or have you received or been prescribed dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
f. been advised by a licensed medical professional that your life expectancy is less than 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
g. had more than one DUI (DWI) violation, been convicted of a felony or are you now on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Do you have any existing life insurance or annuity now in force? (If Yes, describe in Details section) <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Will the issuance of this policy result in the replacement, lapse or termination of any existing life insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Details of Yes answers	

Application for Graded Death Benefit Life Insurance

Fidelity Life Association, A Legal Reserve Life Insurance Company



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.

Printed Name (As it appears on file with the financial institution) **X** _____
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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signed and Dated at (City and State) **X** _____
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? Yes No

Does any Proposed Insured have existing Life Insurance or Annuity contracts in force? Yes No

If any Proposed Insured has existing life or annuity coverage complete the notice regarding replacements.

Copies of the replacement form and all sales material used in the sales presentation are being left with the applicant.

Printed Name of Agent: _____ Agent ID: _____ General Agent ID: _____

State License Number: _____ (If required by law) Agent Email: _____ Agent Telephone: _____