

State: Arkansas
Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: W6M05
Project Name/Number: /

Filing at a Glance

Company: Fidelity Life Association, A Legal Reserve Life Insurance Company
Product Name: W6M05
State: Arkansas
TOI: L04G Group Life - Term
Sub-TOI: L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Filing Type: Form
Date Submitted: 09/10/2012
SERFF Tr Num: FDLR-128673900
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: On Approval
Date Requested:
Author(s): Barbara Mooney
Reviewer(s): Linda Bird (primary)
Disposition Date: 09/17/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
Filing Company: Fidelity Life Association, A Legal Reserve Life Insurance Company
TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: W6M05
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General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Employer, Association, Other Explanation for Other Group Market Type: Union
Overall Rate Impact: Filing Status Changed: 09/17/2012
 State Status Changed: 09/17/2012
Deemer Date: Created By: Barbara Mooney
Submitted By: Barbara Mooney Corresponding Filing Tracking Number:
Filing Description:
 Please review the cover letter.

Company and Contact

Filing Contact Information

Ciaran Brady, Vice President - Operations Ciaran.Brady@FLA-Life.com
 1211 W 22nd St, Suite 209 630-522-0392 [Phone]
 Oak Brook, IL 60523 630-522-0397 [FAX]

Filing Company Information

Fidelity Life Association, A Legal Reserve Life Insurance Company
 1211 W 22nd St.
 Suite 209
 Oak Brook, IL 60523
 (630) 522-0392 ext. [Phone]

CoCode: 63290 State of Domicile: Illinois
 Group Code: 3413 Company Type: Life
 Group Name: State ID Number:
 FEIN Number: 36-1068685

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? Yes
Fee Explanation: 1 form at \$50
Per Company: No

Company	Amount	Date Processed	Transaction #
Fidelity Life Association, A Legal Reserve Life Insurance Company	\$50.00	09/10/2012	62543947

SERFF Tracking #:

FDLR-128673900

State Tracking #:**Company Tracking #:****State:** Arkansas**Filing Company:**

Fidelity Life Association, A Legal Reserve Life Insurance Company

TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium**Product Name:** W6M05**Project Name/Number:** /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/17/2012	09/17/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Enrollment Form	Barbara Mooney	09/13/2012	09/13/2012
Supporting Document	Red-Lined Version	Barbara Mooney	09/13/2012	09/13/2012
Form	Enrollment Form	Barbara Mooney	09/11/2012	09/11/2012
Supporting Document	Red-Lined Version	Barbara Mooney	09/11/2012	09/11/2012

SERFF Tracking #:

FDLR-128673900

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Fidelity Life Association, A Legal Reserve Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name:

W6M05

Project Name/Number:

/

Disposition

Disposition Date: 09/17/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Filing Authorization		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Cover Letter		Yes
Supporting Document (revised)	Red-Lined Version		Yes
Supporting Document	Red-Lined Version	Replaced	Yes
Form (revised)	Enrollment Form		Yes
Form	Enrollment Form	Replaced	Yes
Form	Enrollment Form	Replaced	Yes

SERFF Tracking #:

FDLR-128673900

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

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Product Name: W6M05

Project Name/Number: /

Amendment Letter

Submitted Date: 09/13/2012

Comments:

W6M05 Amendment - The reason for this amendment is to correct the question numbering on page 2.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
W6M05-092012	Application/Enrollment Form	Enrollment Form	Initial					W6M05-092012.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Red-Lined Version

Comment:

W6M05-092012 RedLined.pdf

Submitted Date: 09/11/2012

Comments:

W6M05 Amendment - The reason for this amendment is to correct the question numbering on page 2.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
W6M05-2012	Application/Enrollment Form	Enrollment Form	Initial					W6M05-2012.pdf

SERFF Tracking #:

FDLR-128673900

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

Fidelity Life Association, A Legal Reserve Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name:

W6M05

Project Name/Number:

/

Supporting Document Schedule Item Changes:

User Added -Name: Red-Lined Version

Comment:

W6M05-2012 RedLined.pdf

SERFF Tracking #:

FDLR-128673900

State Tracking #:

Company Tracking #:

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TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: W6M05

Project Name/Number: /

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1		W6M05-092012	AEF	Enrollment Form	Initial:		W6M05-092012.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

New Enrollment Reinstatement

SECTION 1 - [PARTICIPATING EMPLOYER OR ENTITY]

[Participating Employer or Entity:]

SECTION 2 - APPLICANT

Applicant (Give Full Legal Name) Date of Hire: Location/Dept. ID#
Male Female Social Security #

Current Legal Residence: Street Apt No. City State Zip

Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Are you a United States Citizen or do you have Permanent Resident Status? Yes No If no, explain.

[Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment]?
Yes No If no, explain.

SECTION 2 - OTHER INSURED

Other Insured (Give Full Legal Name) Male Female Relationship Social Security # Occupation:

Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Is the Other Insured a United States Citizen or does he/she have a Permanent Resident Status? Yes No If no, explain.

SECTION 3 - COVERAGE APPLIED FOR

Applicant Other Insured
Plan: Face Amount: Plan: Face Amount:
Basic Planned Premium Mode: Weekly Other
Benefit: Basic Planned Periodic Premium
Waiver of Premium
Accidental Death Benefit
Dependent Child Benefit: # Units
Other
Total Planned Periodic Premium

SECTION 4 - COVERAGE APPLIED FOR DEPENDENT CHILDREN

Complete for all Dependent Children for whom individual coverage is being applied for:

Table with 7 columns: Name, Sex, Date of Birth, Age, Relationship to Applicant, Plan Face Amount, Premium

SECTION 5 - BENEFICIARY INFORMATION

The Applicant will be the Beneficiary of any coverage(s) issued on any Dependent Children unless subsequently changed. The Applicant will be the Beneficiary of any coverage(s) issued on the Other Insured, unless otherwise stated in this section. The Spouse will be the Beneficiary of any coverage issued on the Applicant, unless otherwise stated in this section. Please indicate a Contingent Beneficiary in the event the beneficiary does not survive the Proposed Insured.

Primary Beneficiary - Applicant Relationship Primary Beneficiary - Other Insured Relationship
Contingent Beneficiary - Applicant Relationship Contingent Beneficiary - Other Insured Relationship

If more space is needed for the beneficiary designation, attach a signed and dated additional sheet of paper

SECTION 6 - CERTIFICATE HOLDER

The Applicant will be the Certificate Holder for any coverage issued on the Applicant, Other Insured or Dependent Child coverage unless another is subsequently designated.

SECTION 7 - MODIFIED CONDITIONAL ISSUE ELIGIBILITY

Are you currently receiving disability payments? No Yes

SECTION 8 - CONDITIONAL ISSUE ELIGIBILITY

Please answer all required questions for each Proposed Insured. If any question 1,3,4 or 5 is answered "Yes", please answer all of the Simplified Eligibility questions on Page 2 and give details for any "Yes" answers.

Table with 4 columns: Question, Applicant, Other Insured, Dependent Child. Contains 5 eligibility questions.

SECTION 9 - OTHER COVERAGE

Does the Applicant, Other Insured or any Dependent Child, if any, have any life insurance or annuity contract in force or is any application for life insurance or annuity contract reinstatement now pending? No Yes If Yes, complete the following:

Table with 5 columns: Applicant, Other Insured or Child, Name of Company, Face Amount, Month/Year Issued, To be Replaced?

SECTION 10- SIMPLIFIED ELIGIBILITY

Applicant Height: ___ Ft. ___ In. Weight _____ lbs. Other Insured Height: ___ Ft. ___ In. Weight _____ lbs.

6. Has any proposed insured ever been treated for or diagnosed as having?: (Check only those conditions that apply)

	Applicant	Other Insured		Applicant	Other Insured
a. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	i. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	j. Reproductive organ disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Cancer or Tumor?	<input type="checkbox"/>	<input type="checkbox"/>	k. Lung or respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	l. Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Stomach or intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	m. Stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	n. Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>

7. Has any person proposed for insurance: (Check only those conditions that apply)

	Applicant	Other Insured
a. Had an application declined, postponed or offered on a basis other than applied for?	<input type="checkbox"/>	<input type="checkbox"/>
b. Within the past 5 years had, or been advised to have, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance?	<input type="checkbox"/>	<input type="checkbox"/>
c. Taken any prescription medication in the past 6 months? (If "Yes", state name of medication, reason for taking, frequency and dosage.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study, operation or treatment in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
e. Other than stated above, within the past 5 years, had any other illness, operation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 11 - DETAILS OF "YES" ANSWERS

Provide full details of "yes" answers on Page 1 and any Checked responses above, including the diagnoses, date, duration, and names and address of all attending physicians and medical facilities.

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

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

SECTION 12 - 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, my driving record, avocations, insurance history, occupation and hobbies 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.

SIGNED AND DATED AT: (City, State and Date)	SIGNATURE OF LICENSED AGENT:
SIGNATURE OF APPLICANT:	SIGNATURE OF OTHER INSURED: (If any)

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, does the applicant have existing life insurance policies or annuity contracts? Yes No

If yes, to the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of the proposed insured? (If Yes, complete appropriate State replacement forms) Yes No

PRINTED NAME OF AGENT:	STATE LICENSE NUMBER: (if required by law)
AGENT ID:	GENERAL AGENT ID:

SERFF Tracking #:

FDLR-128673900

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

Fidelity Life Association, A Legal Reserve Life Insurance Company

TOI/Sub-TOI: L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: W6M05

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Filing Authorization		
Comments:			
Attachment(s):			
Filing Auth 042012.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
Stmt of Variability.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter		
Comments:			
Attachment(s):			
Letter.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Red-Lined Version		
Comments:			
Attachment(s):			
W6M05-092012 RedLined.pdf			



Fidelity Life Association
8700 W. Bryn Mawr Ave., Ste 900S
Chicago, IL 60631
Tel 630.522.0392
Fax 866.375.8175

April 10, 2012

Company NAIC Number: 63290
Company FEIN Number: 95-1060502

Re: Group Life Insurance Policy, Certificate and Benefit Forms
Letter of Authorization

To: All State Insurance Departments

The Fidelity Life Association, A Legal Reserve Life Insurance Company of 8700 W. Bryn Mawr Ave, Ste. 900S, Chicago, Illinois hereby authorizes Vision Financial Corporation to represent us in the submission of the captioned forms and to negotiate with insurance departments for their approval.

Sincerely,

A handwritten signature in blue ink, appearing to be 'C. Brady', written over a horizontal line.

Ciaran Brady
Vice President of Operations

STATEMENT OF VARIABILITY

Form Number – W6M05

Description – Enrollment Form

Page Variable is Reflected On	Variable Language	Variable Text
1	Section 1	This section will reflect the information necessary to identify the group and the employee or member.
1	Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment?	The question as stated will be asked of Employees of Employer Groups. The question will be modified for Association Members to read: Are you an active member of the Association.
1	Section 2	This section will reflect the name, gender, date of birth, age and smoking classification for each proposed covered insured person.
1	Section 3	This section will reflect the coverage amounts and optional benefits for each proposed covered insured person.
1	Section 4	Reflects information regarding coverage applied for dependent children
1	Section 5	Reflects any unique beneficiary designation.
1	Section 8	Reflects the conditional issue underwriting questions for the proposed covered insured person.
1	Section 8 – Question 1	Period of time can be changed for certain enrollments (3,6,9,12 Months)
1	Section 8 – Question 3	Period of time can be changed for certain enrollments (3,6,9,12 Months)
1	Section 8 – Question 4	Period of time can be changed for certain enrollments (3,6,9,12 Months)
1	Section 9	Reflects the information regarding existing coverage or replacement activity for each proposed covered insured person.
1,2	Home Office Address	Will only change if the physical address of the Home Office Changes
2	Section 10	Reflects the simplified issue underwriting questions for the proposed covered insured person.
2	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.	<p>This statement will be changed for special enrollment situations where the enrollment may occur during a period in which deductions can not occur until several months later. Example: school systems where the enrollment may take place in June prior to the school closing for the summer and the deductions will be help until September when school starts up again. In this case the wording would read:</p> <p>The insurance being applied for will be effective as of the Coverage Date on the Certificate Schedule Page and not the date the enrollment form is signed.</p>

September 10, 2012

Life Policy Analyst
Life and Health Division
Arkansas Insurance Department
1200 West 3rd St.
Little Rock, AR 72201

RE: Fidelity Life Association
NAIC No.: 63290
FEIN Number: 36-1068685
Group Enrollment Form – Form W6M05

Dear Sir or Madam:

We are submitting the Group Enrollment Form identified above for your review and approval. This is a new form and will not replace any form previously approved by your Department.

This form will be used with the Lifetime Benefit Term contract previously approved by your Department or with any additional products that may be approved in the future.

This form does not contain any unusual or possibly controversial items, or provisions that deviate from normal company or industry standards.

Thank you for your assistance with this filing. If you have any questions, please call me at 1-800-635-4467, ext. 209.

Sincerely,

Crystle Harmon
Compliance Coordinator
Vision Financial Corporation
Telephone: 800-635-4467, ext. 209
Fax: 603-357-0250
Email: charmon@visfin.com

Enc.

New Enrollment Reinstatement

SECTION 1 - [PARTICIPATING EMPLOYER OR ENTITY]

[Participating Employer or Entity:]

SECTION 2 - APPLICANT

Applicant (Give Full Legal Name) Date of Hire: Location/Dept. ID#
Male Female Social Security #

Current Legal Residence: Street Apt No. City State Zip

Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Are you a United States Citizen or do you have Permanent Resident Status? Yes No If no, explain.

[Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment?]

Yes No If no, explain.

SECTION 2 - OTHER INSURED

Other Insured (Give Full Legal Name) Male Female Relationship Social Security # Occupation:
Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Is the Other Insured a United States Citizen or does he/she have a Permanent Resident Status? Yes No If no, explain.

SECTION 3 - COVERAGE APPLIED FOR

Applicant Other Insured
Plan: Face Amount: Plan: Face Amount:
Basic Planned Premium Mode: Weekly Other
Benefit: Basic Planned Periodic Premium
Waiver of Premium
Accidental Death Benefit
Dependent Child Benefit: # Units
Other
Total Planned Periodic Premium

SECTION 4 - COVERAGE APPLIED FOR DEPENDENT CHILDREN

Complete for all Dependent Children for whom individual coverage is being applied for:

Table with 7 columns: Name, Sex, Date of Birth, Age, Relationship to Applicant, Plan Face Amount, Premium

SECTION 5 - BENEFICIARY INFORMATION

The Applicant will be the Beneficiary of any coverage(s) issued on any Dependent Children unless subsequently changed. The Applicant will be the Beneficiary of any coverage(s) issued on the Other Insured, unless otherwise stated in this section. The Spouse will be the Beneficiary of any coverage issued on the Applicant, unless otherwise stated in this section. Please indicate a Contingent Beneficiary in the event the beneficiary does not survive the Proposed Insured.

Primary Beneficiary - Applicant Relationship Primary Beneficiary - Other Insured Relationship
Contingent Beneficiary - Applicant Relationship Contingent Beneficiary - Other Insured Relationship

If more space is needed for the beneficiary designation, attach a signed and dated additional sheet of paper

SECTION 6 - CERTIFICATE HOLDER

The Applicant will be the Certificate Holder for any coverage issued on the Applicant, Other Insured or Dependent Child coverage unless another is subsequently designated.

SECTION 7 - MODIFIED CONDITIONAL ISSUE ELIGIBILITY

Are you currently receiving disability payments? No Yes

SECTION 8 - CONDITIONAL ISSUE ELIGIBILITY

Please answer all required questions for each Proposed Insured. If any question 1,3,4 or 5 is answered "Yes", please answer all of the Simplified Eligibility questions 5-6 on Page 2 and give details for any "Yes" answers on Page 2.

Table with 4 columns: Question, Applicant, Other Insured, Dependent Child. Contains 5 eligibility questions.

SECTION 9 - OTHER COVERAGE

Does the Applicant, Other Insured or any Dependent Child, if any, have any life insurance or annuity contract in force or is any application for life insurance or annuity contract reinstatement now pending? No Yes If Yes, complete the following:

Table with 5 columns: Applicant, Other Insured or Child, Name of Company, Face Amount, Month/Year Issued, To be Replaced?

SECTION 10- SIMPLIFIED ELIGIBILITY

Applicant Height: ___ Ft. ___ In. Weight _____ lbs. Other Insured Height: ___ Ft. ___ In. Weight _____ lbs.

69. Has any proposed insured ever been treated for or diagnosed as having?: (Check only those conditions that apply)

	Applicant	Other Insured		Applicant	Other Insured
a. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	i. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	j. Reproductive organ disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Cancer or Tumor?	<input type="checkbox"/>	<input type="checkbox"/>	k. Lung or respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	l. Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Stomach or intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	m. Stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	n. Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>

74. Has any person proposed for insurance: (Check only those conditions that apply)

	Applicant	Other Insured
a. Had an application declined, postponed or offered on a basis other than applied for?	<input type="checkbox"/>	<input type="checkbox"/>
b. Within the past 5 years had, or been advised to have, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance?	<input type="checkbox"/>	<input type="checkbox"/>
c. Taken any prescription medication in the past 6 months? (If "Yes", state name of medication, reason for taking, frequency and dosage.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study, operation or treatment in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
e. Other than stated above, within the past 5 years, had any other illness, operation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 11 - DETAILS OF "YES" ANSWERS

Provide full details of "yes" answers on Page 1 and any Checked responses above, including the diagnoses, date, duration, and names and address of all attending physicians and medical facilities.

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

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

SECTION 12 - 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, my driving record, avocations, insurance history, occupation and hobbies 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.

SIGNED AND DATED AT: (City, State and Date)	SIGNATURE OF LICENSED AGENT:
SIGNATURE OF APPLICANT:	SIGNATURE OF OTHER INSURED: (If any)

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, does the applicant have existing life insurance policies or annuity contracts? Yes No

If yes, to the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of the proposed insured? (If Yes, complete appropriate State replacement forms) Yes No

PRINTED NAME OF AGENT:	STATE LICENSE NUMBER: (if required by law)
AGENT ID:	GENERAL AGENT ID:

SERFF Tracking #:

FDLR-128673900

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

Fidelity Life Association, A Legal Reserve Life Insurance Company

TOI/Sub-TOI:

L04G Group Life - Term/L04G.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name:

W6M05

Project Name/Number:

/

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/11/2012	Form	Enrollment Form	09/13/2012	W6M05-2012.pdf (Superseded)
09/11/2012	Supporting Document	Red-Lined Version	09/13/2012	W6M05-2012 RedLined.pdf (Superseded)
09/06/2012	Form	Enrollment Form	09/11/2012	W6M05.pdf (Superseded)

New Enrollment Reinstatement

SECTION 1 - [PARTICIPATING EMPLOYER OR ENTITY]

[Participating Employer or Entity:]

SECTION 2 - APPLICANT

Applicant (Give Full Legal Name) Date of Hire: Location/Dept. ID#
Male Female Social Security #

Current Legal Residence: Street Apt No. City State Zip

Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Are you a United States Citizen or do you have Permanent Resident Status? Yes No If no, explain.

[Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment]?
Yes No If no, explain.

SECTION 2 - OTHER INSURED

Other Insured (Give Full Legal Name) Male Female Relationship Social Security # Occupation:

Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Is the Other Insured a United States Citizen or does he/she have a Permanent Resident Status? Yes No If no, explain.

SECTION 3 - COVERAGE APPLIED FOR

Applicant Other Insured
Plan: Face Amount: Plan: Face Amount:
Basic Planned Premium Mode: Weekly Other
Benefit: Basic Planned Periodic Premium
Waiver of Premium
Accidental Death Benefit
Dependent Child Benefit: # Units
Other
Total Planned Periodic Premium

SECTION 4 - COVERAGE APPLIED FOR DEPENDENT CHILDREN

Complete for all Dependent Children for whom individual coverage is being applied for:

Table with 7 columns: Name, Sex, Date of Birth, Age, Relationship to Applicant, Plan Face Amount, Premium

SECTION 5 - BENEFICIARY INFORMATION

The Applicant will be the Beneficiary of any coverage(s) issued on any Dependent Children unless subsequently changed. The Applicant will be the Beneficiary of any coverage(s) issued on the Other Insured, unless otherwise stated in this section. The Spouse will be the Beneficiary of any coverage issued on the Applicant, unless otherwise stated in this section. Please indicate a Contingent Beneficiary in the event the beneficiary does not survive the Proposed Insured.

Primary Beneficiary - Applicant Relationship Primary Beneficiary - Other Insured Relationship
Contingent Beneficiary - Applicant Relationship Contingent Beneficiary - Other Insured Relationship

If more space is needed for the beneficiary designation, attach a signed and dated additional sheet of paper

SECTION 6 - CERTIFICATE HOLDER

The Applicant will be the Certificate Holder for any coverage issued on the Applicant, Other Insured or Dependent Child coverage unless another is subsequently designated.

SECTION 7 - MODIFIED CONDITIONAL ISSUE ELIGIBILITY

Are you currently receiving disability payments? No Yes

SECTION 8 - CONDITIONAL ISSUE ELIGIBILITY

Please answer all required questions for each Proposed Insured. If any question 1,3,4 or 5 is answered "Yes", please answer all of the Simplified Eligibility questions 5 - 6 and give details for any "Yes" answers on Page 2.

Table with 4 columns: Question, Applicant, Other Insured, Dependent Child. Contains 5 eligibility questions.

SECTION 9 - OTHER COVERAGE

Does the Applicant, Other Insured or any Dependent Child, if any, have any life insurance or annuity contract in force or is any application for life insurance or annuity contract reinstatement now pending? No Yes If Yes, complete the following:

Table with 5 columns: Applicant, Other Insured or Child, Name of Company, Face Amount, Month/Year Issued, To be Replaced?

SECTION 10- SIMPLIFIED ELIGIBILITY

Applicant Height: ___ Ft. ___ In. Weight _____ lbs. Other Insured Height: ___ Ft. ___ In. Weight _____ lbs.

6. Has any proposed insured ever been treated for or diagnosed as having?: (Check only those conditions that apply)

	Applicant	Other Insured		Applicant	Other Insured
a. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	i. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	j. Reproductive organ disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Cancer or Tumor?	<input type="checkbox"/>	<input type="checkbox"/>	k. Lung or respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	l. Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Stomach or intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	m. Stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	n. Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>

7. Has any person proposed for insurance: (Check only those conditions that apply)

	Applicant	Other Insured
a. Had an application declined, postponed or offered on a basis other than applied for?	<input type="checkbox"/>	<input type="checkbox"/>
b. Within the past 5 years had, or been advised to have, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance?	<input type="checkbox"/>	<input type="checkbox"/>
c. Taken any prescription medication in the past 6 months? (If "Yes", state name of medication, reason for taking, frequency and dosage.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study, operation or treatment in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
e. Other than stated above, within the past 5 years, had any other illness, operation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 11 - DETAILS OF "YES" ANSWERS

Provide full details of "yes" answers on Page 1 and any Checked responses above, including the diagnoses, date, duration, and names and address of all attending physicians and medical facilities.

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

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

SECTION 12 - 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, my driving record, avocations, insurance history, occupation and hobbies 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.

SIGNED AND DATED AT: (City, State and Date)	SIGNATURE OF LICENSED AGENT:
SIGNATURE OF APPLICANT:	SIGNATURE OF OTHER INSURED: (If any)

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, does the applicant have existing life insurance policies or annuity contracts? Yes No

If yes, to the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of the proposed insured? (If Yes, complete appropriate State replacement forms) Yes No

PRINTED NAME OF AGENT:	STATE LICENSE NUMBER: (if required by law)
AGENT ID:	GENERAL AGENT ID:

New Enrollment Reinstatement

SECTION 1 - [PARTICIPATING EMPLOYER OR ENTITY]

[Participating Employer or Entity:]

SECTION 2 - APPLICANT

Applicant (Give Full Legal Name) Date of Hire: Location/Dept. ID#
Male Female Social Security #

Current Legal Residence: Street Apt No. City State Zip

Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Are you a United States Citizen or do you have Permanent Resident Status? Yes No If no, explain.

[Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment?]

Yes No If no, explain.

SECTION 2 - OTHER INSURED

Other Insured (Give Full Legal Name) Male Female Relationship Social Security # Occupation:
Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Is the Other Insured a United States Citizen or does he/she have a Permanent Resident Status? Yes No If no, explain.

SECTION 3 - COVERAGE APPLIED FOR

Applicant Other Insured
Plan: Face Amount: Plan: Face Amount:
Basic Planned Premium Mode: Weekly Other
Benefit: Basic Planned Periodic Premium
Waiver of Premium
Accidental Death Benefit
Dependent Child Benefit: # Units
Other
Total Planned Periodic Premium

SECTION 4 - COVERAGE APPLIED FOR DEPENDENT CHILDREN

Complete for all Dependent Children for whom individual coverage is being applied for:
Table with columns: Name, Sex, Date of Birth, Age, Relationship to Applicant, Plan Face Amount, Premium

SECTION 5 - BENEFICIARY INFORMATION

The Applicant will be the Beneficiary of any coverage(s) issued on any Dependent Children unless subsequently changed. The Applicant will be the Beneficiary of any coverage(s) issued on the Other Insured, unless otherwise stated in this section. The Spouse will be the Beneficiary of any coverage issued on the Applicant, unless otherwise stated in this section. Please indicate a Contingent Beneficiary in the event the beneficiary does not survive the Proposed Insured.

Primary Beneficiary - Applicant Relationship Primary Beneficiary - Other Insured Relationship
Contingent Beneficiary - Applicant Relationship Contingent Beneficiary - Other Insured Relationship

If more space is needed for the beneficiary designation, attach a signed and dated additional sheet of paper

SECTION 6 - CERTIFICATE HOLDER

The Applicant will be the Certificate Holder for any coverage issued on the Applicant, Other Insured or Dependent Child coverage unless another is subsequently designated.

SECTION 7 - MODIFIED CONDITIONAL ISSUE ELIGIBILITY

Are you currently receiving disability payments? No Yes

SECTION 8 - CONDITIONAL ISSUE ELIGIBILITY

Please answer all required questions for each Proposed Insured. If any question 1,3,4 or 5 is answered "Yes", please answer all of the Simplified Eligibility questions 5 - 6 and give details for any "Yes" answers on Page 2.

Table with 4 columns: Question, Applicant, Other Insured, Dependent Child. Contains 5 eligibility questions regarding work absence, tobacco use, medical treatment, physician visits, and AIDS/HIV diagnosis.

SECTION 9 - OTHER COVERAGE

Does the Applicant, Other Insured or any Dependent Child, if any, have any life insurance or annuity contract in force or is any application for life insurance or annuity contract reinstatement now pending? No Yes If Yes, complete the following:

Table with 5 columns: Applicant, Other Insured or Child, Name of Company, Face Amount, Month/Year Issued, To be Replaced? (Yes/No)

SECTION 10- SIMPLIFIED ELIGIBILITY

Applicant Height: ___ Ft. ___ In. Weight _____ lbs. Other Insured Height: ___ Ft. ___ In. Weight _____ lbs.

56. Has any proposed insured ever been treated for or diagnosed as having?: (Check only those conditions that apply)

	Applicant	Other Insured		Applicant	Other Insured
a. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	i. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	j. Reproductive organ disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Cancer or Tumor?	<input type="checkbox"/>	<input type="checkbox"/>	k. Lung or respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	l. Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Stomach or intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	m. Stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	n. Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>

67. Has any person proposed for insurance: (Check only those conditions that apply)

	Applicant	Other Insured
a. Had an application declined, postponed or offered on a basis other than applied for?	<input type="checkbox"/>	<input type="checkbox"/>
b. Within the past 5 years had, or been advised to have, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance?	<input type="checkbox"/>	<input type="checkbox"/>
c. Taken any prescription medication in the past 6 months? (If "Yes", state name of medication, reason for taking, frequency and dosage.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study, operation or treatment in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
e. Other than stated above, within the past 5 years, had any other illness, operation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 11 - DETAILS OF "YES" ANSWERS

Provide full details of "yes" answers on Page 1 and any Checked responses above, including the diagnoses, date, duration, and names and address of all attending physicians and medical facilities.

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

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

SECTION 12 - 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, my driving record, avocations, insurance history, occupation and hobbies 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.

SIGNED AND DATED AT: (City, State and Date)	SIGNATURE OF LICENSED AGENT:
SIGNATURE OF APPLICANT:	SIGNATURE OF OTHER INSURED: (If any)

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, does the applicant have existing life insurance policies or annuity contracts? Yes No

If yes, to the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of the proposed insured? (If Yes, complete appropriate State replacement forms) Yes No

PRINTED NAME OF AGENT:	STATE LICENSE NUMBER: (if required by law)
AGENT ID:	GENERAL AGENT ID:

New Enrollment Reinstatement

SECTION 1 - [PARTICIPATING EMPLOYER OR ENTITY]

[Participating Employer or Entity:]

SECTION 2 - APPLICANT

Applicant (Give Full Legal Name) Date of Hire: Location/Dept. ID#
Male Female Social Security #

Current Legal Residence: Street Apt No. City State Zip

Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Are you a United States Citizen or do you have Permanent Resident Status? Yes No If no, explain.

[Are you actively at work performing the regular duties of your job in the usual manner and at the usual place of employment]?
Yes No If no, explain.

SECTION 2 - OTHER INSURED

Other Insured (Give Full Legal Name) Male Female Relationship Social Security # Occupation:

Birth Date: Age Birth State Annual Salary Home/Cell Phone No.: ()

Is the Other Insured a United States Citizen or does he/she have a Permanent Resident Status? Yes No If no, explain.

SECTION 3 - COVERAGE APPLIED FOR

Applicant Other Insured
Plan: Face Amount: Plan: Face Amount:
Basic Planned Premium Mode: Weekly Other
Benefit: Basic Planned Periodic Premium
Waiver of Premium
Accidental Death Benefit
Dependent Child Benefit: # Units
Other
Total Planned Periodic Premium

SECTION 4 - COVERAGE APPLIED FOR DEPENDENT CHILDREN

Complete for all Dependent Children for whom individual coverage is being applied for:

Table with columns: Name, Sex, Date of Birth, Age, Relationship to Applicant, Plan Face Amount, Premium

SECTION 5 - BENEFICIARY INFORMATION

The Applicant will be the Beneficiary of any coverage(s) issued on any Dependent Children unless subsequently changed. The Applicant will be the Beneficiary of any coverage(s) issued on the Other Insured, unless otherwise stated in this section. The Spouse will be the Beneficiary of any coverage issued on the Applicant, unless otherwise stated in this section. Please indicate a Contingent Beneficiary in the event the beneficiary does not survive the Proposed Insured.

Primary Beneficiary - Applicant Relationship Primary Beneficiary - Other Insured Relationship
Contingent Beneficiary - Applicant Relationship Contingent Beneficiary - Other Insured Relationship

If more space is needed for the beneficiary designation, attach a signed and dated additional sheet of paper

SECTION 6 - CERTIFICATE HOLDER

The Applicant will be the Certificate Holder for any coverage issued on the Applicant, Other Insured or Dependent Child coverage unless another is subsequently designated.

SECTION 7 - MODIFIED CONDITIONAL ISSUE ELIGIBILITY

Are you currently receiving disability payments? No Yes

SECTION 8 - CONDITIONAL ISSUE ELIGIBILITY

Please answer all required questions for each Proposed Insured. If any question 1,3,4 or 5 is answered "Yes", please answer all of the Simplified Eligibility questions 5 - 6 and give details for any "Yes" answers on Page 2.

Table with 4 columns: Question, Applicant, Other Insured, Dependent Child. Contains 5 eligibility questions.

SECTION 9 - OTHER COVERAGE

Does the Applicant, Other Insured or any Dependent Child, if any, have any life insurance or annuity contract in force or is any application for life insurance or annuity contract reinstatement now pending? No Yes If Yes, complete the following:

Table with 5 columns: Applicant, Other Insured or Child, Name of Company, Face Amount, Month/Year Issued, To be Replaced?

SECTION 10- SIMPLIFIED ELIGIBILITY

Applicant Height: ___ Ft. ___ In. Weight _____ lbs. Other Insured Height: ___ Ft. ___ In. Weight _____ lbs.

5. Has any proposed insured ever been treated for or diagnosed as having?: (Check only those conditions that apply)

	Applicant	Other Insured		Applicant	Other Insured
a. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	i. Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	j. Reproductive organ disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Cancer or Tumor?	<input type="checkbox"/>	<input type="checkbox"/>	k. Lung or respiratory disease?	<input type="checkbox"/>	<input type="checkbox"/>
e. Mental or psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	l. Blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Stomach or intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	m. Stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	n. Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>

6. Has any person proposed for insurance: (Check only those conditions that apply)

	Applicant	Other Insured
a. Had an application declined, postponed or offered on a basis other than applied for?	<input type="checkbox"/>	<input type="checkbox"/>
b. Within the past 5 years had, or been advised to have, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance?	<input type="checkbox"/>	<input type="checkbox"/>
c. Taken any prescription medication in the past 6 months? (If "Yes", state name of medication, reason for taking, frequency and dosage.)	<input type="checkbox"/>	<input type="checkbox"/>
d. Had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study, operation or treatment in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
e. Other than stated above, within the past 5 years, had any other illness, operation or treatment?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 11 - DETAILS OF "YES" ANSWERS

Provide full details of "yes" answers on Page 1 and any Checked responses above, including the diagnoses, date, duration, and names and address of all attending physicians and medical facilities.

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

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

SECTION 12 - 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, my driving record, avocations, insurance history, occupation and hobbies 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.

SIGNED AND DATED AT: (City, State and Date)	SIGNATURE OF LICENSED AGENT:
SIGNATURE OF APPLICANT:	SIGNATURE OF OTHER INSURED: (If any)

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, does the applicant have existing life insurance policies or annuity contracts? Yes No

If yes, to the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of the proposed insured? (If Yes, complete appropriate State replacement forms) Yes No

PRINTED NAME OF AGENT:	STATE LICENSE NUMBER: (if required by law)
AGENT ID:	GENERAL AGENT ID: