Reset Form Print Form

Application for Life Insurance

Fidelity Life Association, A Legal Reserve Life Insurance Company

FIDELITYLIFE
Established 1896

FIRST INSURED

FIRST INSURED

Full Legal Name of the Proposed Insured: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Place of Birth: _____ Social Security Number: _____

Legal Residence Address: _____ Years: _____

Best Time to Call (if needed): _____ ☐ AM ☐ PM Preferred #: _____ Alternate#: _____

Are you a United States citizen or do you have Permanent Resident Status (a Green Card)? ☐ Yes ☐ No

Driver's License Number: _____ State of Issue: _____

Occupation: _____ Years in this occupation: _____

Employer or Business Name: _____ Annual Income: $ _____

COVERAGE

Product: _____ Face Amount: $ _____ Term Period:_____ years(if applicable)

Name of Mortgage Lender: _____ Amount of Mortgage: $ _____ Date Closed: _____

☐ Dependent Child Rider: $ _____ ☐ Waiver of Premium on Total Disability

☐ Accidental Death Benefit: $ _____ ☐ Return of Premium/Cash Value Rider

☐ Other Insured Rider: $_____ ☐ Involuntary Unemployment

☐ Other Rider or Option: _____ ☐ Disability Income Rider

Mode of Payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (available on Credit/Debit Card or EFT only)

Billing Method: ☐ Direct Bill ☐ Credit Card ☐ EFT NOTE: For credit/debit card or EFT, complete authorization on page 5.

OWNER, BILLING & BENEFICIARY

Policyowner *(The Policyowner will be the 1st Proposed Insured unless otherwise indicated)*

Name of Policyowner: _____ Relationship to 1st Insured: _____ SSN/Tax ID: _____

Policyowner Address: _____

Secondary Addressee *(Optional. This person will receive copies of your overdue premium and lapse notices)*

Name: _____

Mailing address: _____

Beneficiary *(Complex beneficiary designations should be dealt with within the context of a Will)*

Primary:	Percent of Proceeds	Relationship to Insured:	SSN/Tax ID:
_____	_____	_____	_____
_____	_____	_____	_____
Contingent:	**Percent of Proceeds**	**Relationship to Insured:**	**SSN/Tax ID:**
_____	_____	_____	_____

If more space is needed attach a separate, signed and dated sheet of paper.

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SECOND INSURED

SECOND INSURED

Full Legal Name of the Proposed Insured: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Place of Birth: _____ Social Security Number: _____

Legal Residence Address: (if different) _____ Years: _____

Best Time to Call (if needed): _____ ☐AM ☐PM Preferred# : _____ Alternate#: _____

Are you a United States citizen or do you have Permanent Resident Status (a Green Card)? ☐ Yes ☐ No

Driver's License Number: _____ State of Issue: _____

Occupation: _____ Years in this occupation: _____

Employer or Business Name: _____ Annual Income: $ _____

OTHER COVERAGE

	1st Insured	2nd Insured
Do you have any life insurance in force or is any application for life insurance now pending?	☐ Yes ☐ No	☐ Yes ☐ No
Name of Company: _____ Face Amount: $ _____ To Be Replaced?	☐ Yes ☐ No	☐ Yes ☐ No
Name of Company: _____ Face Amount: $ _____ To Be Replaced?	☐ Yes ☐ No	☐ Yes ☐ No
Name of Company: _____ Face Amount: $ _____ To Be Replaced?	☐ Yes ☐ No	☐ Yes ☐ No
Name of Company: _____ Face Amount: $ _____ To Be Replaced?	☐ Yes ☐ No	☐ Yes ☐ No
If this policy is issued, will any other life insurance or annuity be cancelled, terminated, lapsed or not renewed?	☐ Yes ☐ No	☐ Yes ☐ No

PROVIDE DETAILS OF ANY YES ANSWERS IN THE DETAILS SECTION.

PHYSICIAN OF THE INSUREDS

First Insured:

1. Do you have a regular physician? ☐ Yes ☐ No If Yes, give information below. If No, show the last physician seen.
   Name of physician: _____ Date last seen: _____
   Address: _____ Telephone: _____
2. Your Height: _____ ft/in Your Weight: _____ lbs. 2b. Have you lost weight in the past year? ☐Yes _____ lbs ☐ No

Second Insured:

1. Do you have a regular physician? ☐ Yes ☐ No If Yes, give information below. If No, show the last physician seen.
   Name of physician: _____ Date last seen: _____
   Address: _____ Telephone: _____
2. Your Height: _____ ft/in Your Weight: _____ lbs. 2b. Have you lost weight in the past year? ☐Yes _____ lbs ☐ No

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Name of First Proposed Insured:

MEDICAL QUESTIONS OF THE PROPOSED INSUREDS

	First Insured		Second Insured	
	YES	NO	YES	NO
3. Have you ever tested positive for Human Immunodeficiency Virus (HIV) antibodies as part of a test for obtaining insurance?	☐	☐	☐	☐
4. Have you, within the past 10 years, been treated, or recommended for treatment, by a physician for Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐
5. Have you, within the past 10 years, been treated by a physician for or been diagnosed as having:				
a. a heart disorder, including a heart attack (myocardial infarction), angina, irregular heart beat or abnormal heart rhythm (arrhythmia), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke, or transient ischemic attack (TIA or mini-stroke)?	☐	☐	☐	☐
b. diabetes, high blood sugar, sugar in the urine, anemia, blood or platelet disorders, liver disease, kidney disease (other than kidney stones), Crohn's disease, ulcerative colitis, other intestinal disease or pancreatitis?	☐	☐	☐	☐
c. internal cancer or tumor, melanoma, lymphoma, leukemia?	☐	☐	☐	☐
d. Alzheimer's disease (dementia) , memory loss, seizures, mental retardation (including Down's syndrome), Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson's disease, Amyotrophic Lateral Sclerosis (ALS), cerebral palsy or any form of muscular atrophy?	☐	☐	☐	☐
e. sleep apnea, cystic fibrosis, emphysema or chronic obstructive lung disease (COLD), rheumatoid arthritis, paralysis, connective tissue disorder (lupus or scleroderma)?	☐	☐	☐	☐
f. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other disorder of the immune system?	☐	☐	☐	☐
g. enlarged prostate or elevated prostate specific antigen (PSA) or any disorder of the breast?	☐	☐	☐	☐
h. hypertension (high blood pressure), elevated cholesterol, asthma or other respiratory disorder?	☐	☐	☐	☐
i. anxiety, depression, eating disorders or any other psychological or emotional disorders?	☐	☐	☐	☐
6. Have you, within the past 12 months, received disability benefits of any kind or been disabled for more than 30 days?	☐	☐	☐	☐
7. Other than as already disclosed above, are you currently taking any medication (by prescription or over the counter), or receiving medical or mental health treatment of any kind?	☐	☐	☐	☐
8. Was the reason you last consulted your physician for any reason other than as already disclosed above?	☐	☐	☐	☐
9. Have you, within the past 5 years:				
a. been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?	☐	☐	☐	☐
b. used controlled substances such as cocaine, heroin, amphetamines, barbiturates or hallucinogens?	☐	☐	☐	☐
c. been treated by or been advised by a physician to seek treatment for drug or alcohol use?	☐	☐	☐	☐
d. been advised to have any test (except HIV tests), treatment, surgery, hospitalization or consultation with a medical professional which has yet to be completed?	☐	☐	☐	☐
e. had an application for life or health insurance rated up, postponed, declined or denied reinstatement?	☐	☐	☐	☐
10. Has more than one natural parent or sibling died of cancer or heart disease prior to age 60?	☐	☐	☐	☐
11. Have you, within the past 24 months, used any form of tobacco or nicotine product, including cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or nicotine gum?	☐	☐	☐	☐
If yes, have you, within the past 12 months, used any form of tobacco or nicotine product?	☐	☐	☐	☐
12. Have you, within the past 2 years, engaged in or, in the next 2 years do you plan to engage in:				
a. any aviation activity other than as a fare-paying passenger on commercial airlines?	☐	☐	☐	☐
b. any form of scuba diving, hang-gliding, cave exploration, parachuting, mountain, rock or ice climbing, bungee jumping or organized motor racing?	☐	☐	☐	☐
13. Have you, within the past 2 years, had a driver's license suspended, revoked or had more than 3 moving violations?	☐	☐	☐	☐
14. Have you, within the past 5 years, been convicted of driving while under the influence of alcohol or drugs?	☐	☐	☐	☐
15. Are you currently on probation or have you, within the past 5 years, been convicted of a felony?	☐	☐	☐	☐
16. Do you intend to travel, live, or work outside the United States or Canada?	☐	☐	☐	☐

PROVIDE DETAILS OF ANY YES ANSWERS IN THE DETAILS SECTION.

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Name of First Proposed Insured:

B - DEPENDENT CHILD RIDER

LIST ALL DEPENDENT CHILDREN TO BE INSURED
If more space is needed, list full information on all additional dependent children on a separate, signed sheet.

B1. Full Legal Name of Dependent Child: _____ ☐ Male ☐ Female Date of Birth: _____

B2. Full Legal Name of Dependent Child: _____ ☐ Male ☐ Female Date of Birth: _____

B3. Full Legal Name of Dependent Child: _____ ☐ Male ☐ Female Date of Birth: _____

B4. Full Legal Name of Dependent Child: _____ ☐ Male ☐ Female Date of Birth: _____

B5. If this coverage is issued, will any life insurance or annuity on any Child to be insured be cancelled, terminated, lapsed or not renewed? *If Yes, give full details below.* ..... ☐ Yes ☐ No

B6. Does any Child to be insured have any physical disability, mental retardation or special need? ..... ☐ Yes ☐ No

B7. Has any Child to be insured been diagnosed with or treated by a physician for any disorder of the heart or has any surgery or hospitalization been suggested which has not yet been completed? ..... ☐ Yes ☐ No

PROVIDE DETAILS OF ANY YES ANSWERS IN THE DETAILS SECTION

DETAILS OF YES ANSWERES (IF ANY) ON ALL INSUREDS

Show question being answered, the condition(s), the name, address and phone number(s) of the physician(s) and the prescribed medication(s).

Question Answer

Application for Life Insurance

Fidelity Life Association, A Legal Reserve Life Insurance Company

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Name of First Proposed Insured:

PREAUTHORIZED PAYMENT AUTHORIZATION

As a convenience to me, I authorize Fidelity Life Association, A Legal Reserve Life Insurance Company, hereinafter known as "Fidelity Life Association", to make electronic debits or other forms of preauthorized withdrawals from my financial institution as indicated below. I understand that if a debit or withdrawal is not honored by the financial institution, Fidelity Life Association will consider the premium unpaid. Any debit or withdrawal returned due to insufficient funds may be redeposited by Fidelity Life Association at its sole discretion. This authorization will remain in effect until written notice by the depositor/card holder is received by Fidelity Life Association. I further agree that if any such debit or withdrawal is not honored, whether with or without cause, Fidelity Life Association shall be under no liability whatsoever even though such dishonor results in the lapse of insurance.

PRE-AUTHORIZED CHECK

☐ I request that my premium payments be debited from my bank account as shown.

Name of Bank: _____ Transit Number: _____ Account Number: _____

PRE-AUTHORIZED CREDIT / DEBIT CARD This selection will apply to all payments unless otherwise indicated.

☐ I request that my premium payments be debited from the ☐credit ☐debit card shown below.

☐ Visa ☐ Amex ☐ MasterCard ☐ Discover Card Number: _____ Expiration Date: _____

_____ X _____

Printed Name *(As it appears on file with the financial institution)* AUTHORIZED SIGNATURE

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I declare that each answer 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 Association 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. I also understand that Fidelity Life Association 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: (a) health; (b) habits; (c) occupation; and (d) any other condition relating to the Proposed Insured are as described in the application.

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 Medical Information Bureau (MIB), consumer reporting agency 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, 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 Association 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 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, the Medical Information Bureau (MIB), 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 knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of criminal offense under state law.

_____ X _____

Signed and Dated at (State and Date): Signature of First Proposed Insured

X _____ X _____

Signature of Policyowner, if other than the Insured Signature of Second Proposed Insured

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 the Proposed Insured? (If Yes, complete appropriate State replacement forms) ☐ Yes ☐ No

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

Email Address of Agent: _____ Telephone Number of Agent: _____

State License Number: _____(If required by law) Signature of Licensed Agent X _____

NOTICE OF INSURANCE INFORMATION PRACTICES

Fidelity Life Association, A Legal Reserve Life Insurance Company

We appreciate your application and thank you for choosing **Fidelity Life Association** for your life insurance needs. In order for us to continue to provide cost effective coverage to our clients, we need to evaluate each application fully. To complete our underwriting evaluation, we may need to obtain medical and other personal information about you. When you sign the Declaration, Agreement and Authorization to Release Information section of the application, you give us permission to obtain that information and give permission to others who have that information to send it to us.

We recognize our obligation to protect your privacy and the confidentiality of underwriting information we obtain about you. For that reason, we have procedures for obtaining information and controlling access to our files that we want you to know about it. In addition, Federal and State regulators require that certain information about the underwriting process be given to you. This information is included in the following paragraphs.

Insurance Information Practices. To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. Although the information we obtain about you is confidential, in some cases we may disclose information to others without your specific authorization. We will furnish a more detailed summary of our information practices upon request.

Fair Credit Reporting. As part of our evaluation of your application, an investigative consumer report may be prepared, whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health and mode of living. Upon your written request and within a reasonable period of time, you have the right to receive additional information about the nature and the scope of the investigation and to receive a copy of the report at your expense.

MlB, Inc. Information regarding your insurability will be treated as confidential. Fidelity Life Association, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member for Life or Health insurance, or a claim for benefits is submitted to such a company MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866.692.6901. If you question the accuracy of any information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Suite 400, 50 Braintree Hill Park, Braintree, Massachusetts 01284-8734.

Fidelity Life Association, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS NOTICE IS TO BE LEFT WITH THE APPLICANT

HIPAA AUTHORIZATION

Fidelity Life Association, A Legal Reserve Life Insurance Company

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Authorization for the Release of personal Health Information

This authorization complies with the **HIPAA** Privacy Rules

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any entity subject to the **Health Insurance Portability and Accountability Act** of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Fidelity Life Association, its agents, employees, representatives, insurance support organizations, and reinsurers (collectively, "the Company"). This includes all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including but not limited to, hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer and/or any entity subject to HIPAA to release and disclose such information without restriction.

I understand that unless prohibited by state and/or Federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by Federal rules governing privacy and confidentiality of health information and may be subject to redisclosure.

This authorization shall remain in force for 26 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company at the address listed above. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application for insurance. I understand that I am entitled to receive a copy of this authorization.

PRINTED NAME OF THE PROPOSED INSURED DATE OF BIRTH

SIGNATURE OF THE PROPOSED INSURED DATED
Or, if applicable, signature of the Personal Representative of the Proposed Insured

If applicable, description of Personal Representative's authority or relationship to Proposed Insured.

THIS PAGE IS TO BE SIGNED AND SENT TO THE COMPANY

CONDITIONAL RECEIPT

Fidelity Life Association, A Legal Reserve Life Insurance Company

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DO NOT complete and give to Applicant UNLESS the first full premium payment is made.

In exchange for the payment of the first required premium with the application, the Company will provide insurance prior to policy delivery, under the following terms.

No insurance will be provided under this Receipt unless all requirements are first fulfilled exactly during the lifetime of the Proposed Insured. If all requirements are not so met, or the Proposed Insured dies by suicide, the liability of the Company shall be limited to a refund to the Applicant of the payment made for this Receipt. Medical requirements are defined by the Company's current rules and practices and include hospital and physician reports, and medical examinations and tests. No agent may alter or waive any part of this Receipt. This Receipt provides no insurance for riders or additional benefits.

Requirements

The following must first be fulfilled for insurance to start:

a. All medical requirements are completed and received by the Company within 60 days from the date of the application;
b. The first premium has been paid in full;
c. All questions in the application have been answered;
d. All answers given in the application are true and complete; and
e. The Proposed Insured is acceptable to the Company under its rules and practices, for the plan and amount applied for, without amendment, at the rate class applied for or a lesser premium, as of the date the Company receives all of its medical requirements.
f. The Proposed Insured has complied with all parts of the Life Application.

Start of Insurance

If the above requirements are first met, this Receipt will provide insurance beginning the latest of: (1) the date of the application; or (2) the date of receipt of all medical requirements by the Company.

End of Insurance

Once begun, any insurance this Receipt may provide ends at the earliest of: (1) 60 days after the date of the application; (2) when the Company sends a refund of the premium which was exchanged for this Receipt; or, (3) the date any policy issued goes into effect.

Amount Limit

The amount of insurance provided by this Receipt is the lesser of: (a) the initial death benefit of the insurance applied for in the application; or (b) $500,000 less all amounts of life insurance and accidental death benefits applied for or in force with the Company.

Payment Terms

The first premium will not be considered paid unless any check, draft, or other instrument of payment (given as premium) is paid in accordance with its terms. All premium checks must be made payable to Fidelity Life Association. **Do not make checks payable to the Agent. Do not leave the payee blank.**

This Receipt is given on behalf of the Company.

I have read and agree to the above terms.

_____ _____
Signature of Owner/Applicant Dated

_____ $ _____
Received from (name of payee) Amount

_____
for coverage on the life of (show name of Proposed Insured)

_____ _____
Signature of licensed Agent Dated

Fidelity Life Association, A Legal Reserve Life Insurance Company
Administrative Office: P.O. Box 5030, Des Plaines, Illinois 60017
(800) 369-3990

NOTICE REGARDING REPLACEMENT

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. That way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature: _____ Date: _____

Applicant's Name Printed: _____

By

Agent's Signature: _____ Date: _____

Agent's Name Printed: _____

To Agent: Complete 2 copies. Leave one with applicant. Send other to Administrative Office with application.

INSURANCE POLICY REPLACEMENT INFORMATION

Fidelity Life Association expects producers to only recommend replacements that are appropriate to customers and confirm that any transaction that involves either an internal (same insurer) or external (another insurer) replacement of an existing policy is appropriate. Fidelity Life Association requires all producers with whom it is contracted to comply fully with their individual state's replacement laws and complete all required replacement forms.

Under the National Association of Insurance Commissioners Life Insurance and Annuities Replacement Model Regulation enacted in a number of states, in connection with the sale of a life insurance or annuity policy, "replacement" includes policies that are:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term life insurance or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or
5. Used in a financed purchase. Financed purchase means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from, values of an existing policy to pay all or part of any premium due on the new policy.

Replacement does not include:

1. Exercise of a contractual change or a conversion privilege with an existing insurer;
2. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same insurer; or
3. Supplanting life insurance that is non-convertible term life insurance that will expire in five (5) years or less and cannot be renewed.

Appropriate replacements are those replacements that are considered in the best interest of the customer. Possible reasons for an appropriate replacement may include improved death benefit, lower charges for the customer or new policy features.

Inappropriate replacements are those replacements that are not considered in the best interest of a customer. A policy that has been in existence for a period of time may have certain advantages over a new policy. Possible advantages for keeping an existing policy may include lower premiums based on initial policy issue age or policy features that may be better under the old policy.

Submission to Fidelity Life Association by a producer of an application that is a proposed replacement will be deemed to constitute a certification by that producer that the proposed replacement is appropriate.

A producer must submit with an application that is a proposed replacement a copy of any preprinted or electronically presented insurer-approved sales materials used and copies of any individualized sales materials. Lack of submission of such materials with an application that is a proposed replacement will be deemed to constitute a certification by that producer that no such sales materials were used in connection with the application.

If you have any questions or need more information about replacements at Fidelity Life Association, please contact our Corporate Counsel by calling our toll-free telephone number at (877) 704-6279.

PRODUCER USE ONLY. PLEASE DO NOT SUBMIT THIS INSURANCE POLICY REPLACEMENT INFORMATION FORM TO FIDELITY LIFE ASSOCIATION.