POLICY SAMPLE
814 SOME STREET
HUNT, IL 60606

Fidelity Life Association
8700 W. Bryn Mawr Ave., Ste. 900S
Chicago, IL 60631
Tel: 800.369.3990 Fax: 866.375.8175

December 14, 2015 Policy # 0900004671

Dear Policy Sample,

We are pleased that you have chosen Fidelity Life to play a role in providing financial security to your loved ones. Since 1896, Fidelity Life Association has offered innovative products and services to our policyholders across the country. You recently purchased a Rapid Decision Life policy and have now completed medical underwriting for the policy. Congratulations on completing this important step that allows us to maximize the value of coverage benefits available under your contract.

As your agent explained, your policy was initially a blend of level term life insurance that pays death benefits for all causes of death coupled with added benefits for accidental death. Based on your underwriting results, the accidental death portion of your blended coverage has been eliminated. This gives you a policy that pays a total benefit amount due to all causes of death other than those excluded under specific provisions of the policy. Please consult your policy wording for details.

Your all cause death benefit is $500,000 with a premium of $43.93 per month. A new policy schedule page is enclosed that should be retained with your policy; this increases your all cause death benefit as indicated above.

We hope that you remain a Fidelity Life policyholder for many years to come. We look forward to serving you.

Sincerely,

New Business Department

Fidelity Life Association

A Legal Reserve Life Insurance Company

8700 W. Bryn Mawr Ave., Ste. 900S
Chicago, IL 60631
(800) 369-3990

STATEMENT OF POLICY COST AND BENEFIT INFORMATION FOR POLICY NUMBER 0900004671

Insured:	POLICY SAMPLE	Agent:	TEST BUSINESS NAME
Insurance Age:	40		123 Main
Premium Class:	Male, Preferred Non-Nicotine for 20 years		
Face Amount:	$500,000		OAK BROOK IL 60523-2109
Policy Date:	December 14, 2015		Agent Number: FLAORPHANW
Date Prepared:	December 14, 2015		

LEVEL DEATH BENEFIT TERM LIFE INSURANCE TO AGE 95

Base Plan Annual Premiums and Benefits

Policy Year	Annual Premium	Death Benefit	Cash Dividend
1	$505.00	$500,000.00	$0.00
2	$505.00	$500,000.00	$0.00
3	$505.00	$500,000.00	$0.00
4	$505.00	$500,000.00	$0.00
5	$505.00	$500,000.00	$0.00
6	$505.00	$500,000.00	$0.00
7	$505.00	$500,000.00	$0.00
8	$505.00	$500,000.00	$0.00
9	$505.00	$500,000.00	$0.00
10	$505.00	$500,000.00	$0.00
11	$505.00	$500,000.00	$0.00
12	$505.00	$500,000.00	$0.00
13	$505.00	$500,000.00	$0.00
14	$505.00	$500,000.00	$0.00
15	$505.00	$500,000.00	$0.00
16	$505.00	$500,000.00	$0.00
17	$505.00	$500,000.00	$0.00
18	$505.00	$500,000.00	$0.00
19	$505.00	$500,000.00	$0.00
20	$505.00	$500,000.00	$0.00
21	$11,215.00	$500,000.00	$0.00
22	$12,465.00	$500,000.00	$0.00
23	$13,990.00	$500,000.00	$0.00
24	$15,705.00	$500,000.00	$0.00
25	$17,505.00	$500,000.00	$0.00
26	$19,405.00	$500,000.00	$0.00
27	$21,330.00	$500,000.00	$0.00
28	$23,280.00	$500,000.00	$0.00
29	$25,380.00	$500,000.00	$0.00
30	$27,555.00	$500,000.00	$0.00
31	$30,190.00	$500,000.00	$0.00
32	$33,140.00	$500,000.00	$0.00
33	$37,015.00	$500,000.00	$0.00
34	$41,105.00	$500,000.00	$0.00
35	$45,405.00	$500,000.00	$0.00
36	$50,105.00	$500,000.00	$0.00
37	$55,230.00	$500,000.00	$0.00
38	$61,180.00	$500,000.00	$0.00
39	$68,130.00	$500,000.00	$0.00
40	$76,155.00	$500,000.00	$0.00
41	$84,905.00	$500,000.00	$0.00

STATEMENT OF POLICY COST AND BENEFIT INFORMATION FOR POLICY NUMBER 0900004671

Insured:	POLICY SAMPLE	Agent:	TEST BUSINESS NAME
Insurance Age:	40		123 Main
Premium Class:	Male, Preferred Non-Nicotine for 20 years		
Face Amount:	$500,000		OAK BROOK IL 60523-2109
Policy Date:	December 14, 2015		Agent Number: FLAORPHANW
Date Prepared:	December 14, 2015		

LEVEL DEATH BENEFIT TERM LIFE INSURANCE TO AGE 95

Base Plan Annual Premiums and Benefits

Policy Year	Annual Premium	Death Benefit	Cash Dividend
42	$94,865.00	$500,000.00	$0.00
43	$105,240.00	$500,000.00	$0.00
44	$116,430.00	$500,000.00	$0.00
45	$128,815.00	$500,000.00	$0.00
46	$142,655.00	$500,000.00	$0.00
47	$157,990.00	$500,000.00	$0.00
48	$174,740.00	$500,000.00	$0.00
49	$192,690.00	$500,000.00	$0.00
50	$211,630.00	$500,000.00	$0.00
51	$231,390.00	$500,000.00	$0.00
52	$249,980.00	$500,000.00	$0.00
53	$269,355.00	$500,000.00	$0.00
54	$289,790.00	$500,000.00	$0.00
55	$311,380.00	$500,000.00	$0.00

No cash values or dividends are payable.

Base Plan Life Insurance-Adjusted Indexes (Calculated at 5 Percent)

	Net Payment Cost Index	Net Surrender Cost Index	Equivalent Level Dividend
YEAR 10	1.01	1.01	0.00
YEAR 20	1.01	1.01	0.00

An explanation of the intended use of the life insurance cost indexes and the equivalent level dividend is included in the Life Insurance Buyer's Guide.

The abbreviation n/a is used when the appropriate value is not applicable.

POLICY SCHEDULE

Policy Number:	0900004671	**Total Face Amount:**	$500,000
Insured:	POLICY SAMPLE	**Gender and Age:**	Male 40
Policyowner:	POLICY SAMPLE	**Policy Date:**	December 14, 2015
Issue Date:	December 14, 2015	**Expiry Date:**	December 14, 2070

Policy Description: Level Death Benefit Term Life Insurance

Beneficiary: As stated in the application or as subsequently changed.

Total Initial Annual Premium: $505.00*

Initial Term Period: 20 years

Premium Class: Preferred Non-Nicotine

Annual Policy Premiums

* The Total Initial Annual Premium shown above includes the $65.00 annual Policy Fee and the premium for any riders, which may be attached to this Policy.

Benefits and Premiums

	Initial Annual Premium**	Years Payable*
Base Policy, including the Policy Fee	$505.00	55
All Cause Death Benefit to Expiry Date	Included	
Total Initial Annual Premium	**$505.00**	

Printed as of December 14, 2015

** After the Initial Premium Period premiums increase annually to age 95. See page 3a for the total annual renewal premiums following the Initial Premium Period.

Death Benefit	All Cause Death	Accidental Death
Policy Years 1 - 20	$500,000	-
Policy Years 21 and after	$500,000	-

Premium Payment Options

You have selected a payment mode of monthly. Monthly premiums equal Your annual premium multiplied by a guaranteed modal factor of 0.087. Changes to Your current payment mode must be requested in writing to Us. Changes in mode, other than to annual mode, will be subject to modal factors and availability as determined by Company rules at the time of the request. Premiums are due and payable on each due date or You risk voluntary termination or reduced benefits in accordance with the Grace Period.

SCHEDULE OF PREMIUMS

Policy Number: 0900004671 **Policy Date:** December 14, 2015

Insured: POLICY SAMPLE **Expiry Date:** December 14, 2070

Policy Year	Attained Age	Annual Premium (Includes Riders)
1	40	$505.00
2	41	$505.00
3	42	$505.00
4	43	$505.00
5	44	$505.00
6	45	$505.00
7	46	$505.00
8	47	$505.00
9	48	$505.00
10	49	$505.00
11	50	$505.00
12	51	$505.00
13	52	$505.00
14	53	$505.00
15	54	$505.00
16	55	$505.00
17	56	$505.00
18	57	$505.00
19	58	$505.00
20	59	$505.00
21	60	$11,215.00
22	61	$12,465.00
23	62	$13,990.00
24	63	$15,705.00
25	64	$17,505.00
26	65	$19,405.00
27	66	$21,330.00
28	67	$23,280.00
29	68	$25,380.00
30	69	$27,555.00
31	70	$30,190.00
32	71	$33,140.00
33	72	$37,015.00
34	73	$41,105.00
35	74	$45,405.00
36	75	$50,105.00
37	76	$55,230.00
38	77	$61,180.00
39	78	$68,130.00
40	79	$76,155.00
41	80	$84,905.00
42	81	$94,865.00
43	82	$105,240.00
44	83	$116,430.00
45	84	$128,815.00
46	85	$142,655.00
47	86	$157,990.00
48	87	$174,740.00
49	88	$192,690.00
50	89	$211,630.00
51	90	$231,390.00
52	91	$249,980.00
53	92	$269,355.00
54	93	$289,790.00
55	94	$311,380.00

Reinstatement Interest Rate **6%**

Application for Individual Life Insurance
Rapid Decision Life Insurance

Fidelity Life Association, A Legal Reserve Life Insurance Company

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PROPOSED INSURED

Full Legal Name of the Proposed Insured: Policy Sample Gender: Male
Legal Residence Address: 814 Some Street, Hunt, IL 60606
Preferred Phone #: (888) 555-1212 Alternate Phone #: (888) 555-2121 Best Time to Call: Any Day; Any Time: (CST)
Email Address: scott.cassavoy@fidelitylife.com
Date of Birth: 12/01/1975 Place of Birth (Country): United States of America / IL Social Security Number: 121-21-2121
Drivers License Number: S12345678901 State of Issue: IL

COVERAGE

Product: Hybrid Life Face Amount: $ 500,000 Term Period (years): 20

OTHER COVERAGE

Do you have any existing life insurance or annuity contracts in force or is any application for life insurance, or reinstatement, now pending with Fidelity Life or any other company? ☐ Yes ☑ No

If this policy is issued, will any other existing life insurance or annuity with Fidelity Life or any other company be cancelled, terminated, lapsed or not renewed? ☐ Yes ☑ No

BENEFICIARY

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

Primary:	% of Benefit:	Relationship to Insured:	SSN/Tax ID:
Policy Sample	100	Wife	212-12-1212

QUESTIONS TO THE PROPOSED INSURED

1. Are you a legal U.S. resident and have you resided in the U.S. for more than 2 years? ☑ Yes ☐ No
2. Are you currently employed? ☑ Yes ☐ No
   - I am not self-employed.
   - My Annual Income is $100,000.
   - My Employer or Business Name is Job.
   - My Primary Occupation is TEACHER.
3. Do you have a Primary Care Physician? ☐ Yes ☑ No
4. Have you seen a Physician within the past 5 years? ☐ Yes ☑ No
5. What is your Height (ft/in)? 6' 0"
6. What is your Weight (lbs)? 200
7. Has your weight changed in the past year? ☐ Yes ☑ No
8. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Irregular Heart Beat (Arrhythmia), Blockage or Narrowing of the Arteries, Stroke, Congestive Heart Failure (CHF), Aneurysm, Malignant Neoplasm, Lymphoma, Melanoma or Leukemia, Pancreatitis, Memory Loss or Dysfunction or Multiple Sclerosis OR any disease or disorder of the Liver? ☐ Yes ☑ No
9. In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Muscular Dystrophy, Parkinson's Disease, Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's Disease), Cerebral Palsy, Systemic Lupus Erythematosus (SLE), Lupus, Scleroderma, Cystic Fibrosis, Alzheimer's Disease, Schizophrenia, Dementia or Mental Retardation (including Down's Syndrome)? ☐ Yes ☑ No
10. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or received a positive result from a test administered by a member of the medical profession for Human Immunodeficiency Virus (HIV)? ☐ Yes ☑ No

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NAME OF PROPOSED INSURED: POLICY SAMPLE

QUESTIONS TO THE PROPOSED INSURED (Continued)

11.	In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Coronary Artery Disease (CAD), Heart Attack (Myocardial Infarction) or Transient Ischemic Attack (TIA or Mini Stroke)?	☐ Yes ☑ No
12.	In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea or Asthma?	☐ Yes ☑ No
13.	In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; major Depression or Anxiety that required psychiatric treatment or other Psychological (Emotional), Mental or Nervous Disorder?	☐ Yes ☑ No
14.	In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; a Tumor or Cancer (excluding basal cell or squamous cell carcinoma of the skin)?	☐ Yes ☑ No
15.	In the past 10 years, have you received any treatment, medical advice or consultation for; been diagnosed by a member of the medical profession with or required follow-up for; Diabetes, Elevated Blood Sugar, Sugar in the Urine, Elevated Cholesterol or Hypertension (High Blood Pressure)?	☐ Yes ☑ No
16.	Have you, within the past 5 years, received medical treatment or counseling for or been advised by a physician to discontinue the use of alcohol or prescribed or non-prescribed drugs?	☐ Yes ☑ No
17.	Have you, within the last 24 months, used any form of Tobacco, Nicotine or Nicotine Products of any kind?	☐ Yes ☑ No
18.	Have you, within the past 5 years, used Controlled Substances such as Narcotics, Cocaine, Heroin, Amphetamines, Hallucinogens or Barbiturates not prescribed by a Physician or have you abused over the counter Medications?	☐ Yes ☑ No
19.	Have you, within the past 5 years, used Marijuana?	☐ Yes ☑ No
20.	Have you, within the past 5 years, been advised by a member of the medical profession to have any Diagnostic Tests (except HIV tests), Treatments, Hospitalizations, Surgical Operations or medical or mental evaluations or consultations with any Medical Professionals, which have yet to be completed, or are you waiting for a diagnosis?	☐ Yes ☑ No
21.	Within the past 5 years, have you been prescribed any medication, suffered from any disease or received any Medical, Mental or Surgical health treatment for any condition that you have not previously disclosed?	☐ Yes ☑ No
22.	Have you, within the past 5 years, been convicted of or pled guilty to a felony or misdemeanor or do you have any such charges pending against you?	☐ Yes ☑ No
23.	Have you, within the past 5 years, had a Drivers License Denied, Suspended, Revoked or been convicted of more than three Moving Violations?	☐ Yes ☑ No
24.	Have you, within the past 5 years, been convicted of or pled guilty to Reckless Driving or Driving while Under the Influence of Alcohol or Drugs or driving while intoxicated?	☐ Yes ☑ No
25.	Have you within the past 5 years requested or received a worker's compensation or disability income payment for more than 90 consecutive days, excluding a pregnancy related payment, or have you been disabled for more than 30 days?	☐ Yes ☑ No
26.	Have you, within the past 2 years, engaged in, or do you plan within the next 2 years to engage in, any Aviation Activity other than as a Fare-Paying Passenger on commercial airlines?	☐ Yes ☑ No
27.	Have you, within the past 2 years, engaged in, or do you plan within the next 2 years to engage in, any form of, Scuba Diving, Hang-Gliding, Cave Exploration, Parachuting, Mountain, Rock or Ice Climbing, Rodeo, Bungee Jumping, Ballooning or Motor Racing?	☐ Yes ☑ No
28.	To the best of your knowledge or belief has any Natural Parent or Sibling died of Diabetes, Cancer or Heart Disease prior to age 60?	☐ Yes ☑ No
29.	Do you intend to Travel, Live or Work outside the United States or Canada within the next 2 years?	☐ Yes ☑ No

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NAME OF PROPOSED INSURED: POLICY SAMPLE

PREAUTHORIZED PAYMENT INFORMATION

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 below. 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 re-deposited by Fidelity Life at its sole discretion. 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.

Payor is Insured

Mode of Payment: Monthly Payment Method: EFT

PRE-AUTHORIZED CHECK *(This selection will apply to all payments)*
I request that my premium payments be debited from my bank account as shown.

Name of Bank: Bank Transit Number: 021272626 Account Number: 82564564

Policy Sample
Printed Name (As it appears on file with the financial institution)

DocuSigned by:
Policy Sample
D4993A517392440...
AUTHORIZED SIGNATURE

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION

I declare that 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 Association, A Legal Reserve Life Insurance Company (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.

I understand that the statements and answers in the application are the basis for any policy issued by Fidelity Life, and that no information will be considered to have been given to the company unless it is stated in the application;
I understand that a sales representative does not have the company's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

The coverage will be effective on its date of issue if the: (a) health; (b) avocations; (c) occupation; and (d) any other condition relating to the Proposed Insured are as described in the application. The effective date will be shown on page 3 of the Policy, provided one is issued.
I understand that Fidelity Life will have no liability until a policy is issued on this application and delivered to and accepted by the owner and the first premium is paid in full while the insured is alive.

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 authorize Fidelity Life or its reinsurers to make a brief report of my protected health information to MIB, Inc.

In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.

NAME OF PROPOSED INSURED: POLICY SAMPLE

DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION (Continued)

I agree that this authorization shall remain in effect for the time limit permitted by applicable law in the state where the policy is delivered or issued for delivery (but no more than 24 months) 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. 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 knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: IL Date: 12/14/2015

DocuSigned by:
Policy Sample
D4993A5173924A0...
Signature of 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 any proposed insured? (If yes, complete appropriate state replacement forms) ☐ Yes ☑ No

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

Printed Name of Agent: TEST BUSINESS NAME
Agent ID: Scottds General Agent ID: FLAORPHAN
Email Address of Agent: FLATest@FidelityLife.com Telephone Number of Agent: 9999999999

Electronically Signed By: TEST BUSINESS NAME
Signature of Licensed Agent

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, pharmacy benefit manager, 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. I authorize Fidelity Life Association or its reinsurers to make a brief report of my protected health information to MIB, Inc.

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, pharmacy benefit manager, 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. 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.

Policy Sample	**12/01/1975**
PRINTED NAME OF THE PROPOSED INSURED	DATE OF BIRTH
DocuSigned by: Policy Sample D4993A5173924A0...	12/14/2015
SIGNATURE OF THE PROPOSED INSURED Or, if applicable, signature of the Personal Representative of the Proposed Insured	DATED

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

THIS PAGE IS TO BE SIGNED AND SENT TO THE COMPANY

FIDELITYLIFE
Established 1896

IMPORTANT NOTICE
REGARDING YOUR APPLICATION FOR INSURANCE

An application for insurance is a document that, if accepted by Us, will become part of a legal contract. Knowingly providing false information, or omitting information, could result in our rescission of your policy or denial of a claim. It may even be a criminal offense if it represents a willful attempt to defraud your insurance company.

It is important to read your application carefully. Please be sure that you have answered the questions fully and truthfully.

In most cases, we do not require you to submit to medical examinations, take blood or other fluid tests. However, with your consent on your application, WE DO ATTEMPT TO VERIFY the information provided. If you have any medical history that is not disclosed in your application or answered "No" to any of the questions that should have been answered as "Yes" it is HIGHLY LIKELY that we will discover it. In this event we will not issue you an insurance policy. In addition, we are required to report any adverse findings to the Medical Information Bureau. This may impact your ability to purchase insurance in the future.

If you misrepresented yourself and it is found after a policy has already been issued, the policy may be rescinded as of its effective date. All premiums received will be refunded. The coverage will be void from its beginning.

Be sure to answer all of the questions. If you have any questions please contact your agent.

Policy Sample

PRINTED NAME OF THE PROPOSED INSURED

DocuSigned by:
Policy Sample
D4993A5173924AD...

12/14/2015

SIGNATURE OF THE PROPOSED INSURED DATED

Fidelity Life Association, A Legal Reserve Life Insurance Company
8700 W. Bryn Mawr Ave., Ste. 900S, Chicago, IL 60631
www.fidelitylife.com