

PLAN INFORMATION:

As selected by the Policyholder

In Hospital Benefit Amounts:

- | | | | |
|----------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> \$500 | <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$3,000 | <input type="checkbox"/> \$6,000 |
| <input type="checkbox"/> \$750 | <input type="checkbox"/> \$1,750 | <input type="checkbox"/> \$3,500 | <input type="checkbox"/> \$7,000 |
| <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$4,000 | <input type="checkbox"/> \$8,000 |
| <input type="checkbox"/> \$1,250 | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 |

- | | | |
|--|--------------------------------|---|
| <input type="checkbox"/> Optional Physician Benefit Rider | <input type="checkbox"/> \$15 | <input type="checkbox"/> \$20 |
| <input type="checkbox"/> Optional Wellness Benefit Rider | <input type="checkbox"/> \$100 | <input type="checkbox"/> \$200 <input type="checkbox"/> \$500 |

Optional Outpatient Benefit II (Individual/Family)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> \$250/\$500 | <input type="checkbox"/> \$500/\$1,000 | <input type="checkbox"/> \$750/\$1,500 | <input type="checkbox"/> \$1,000/\$2,000 |
| <input type="checkbox"/> \$1,250/\$2,500 | <input type="checkbox"/> \$1,500/\$3,000 | <input type="checkbox"/> \$1,750/\$3,500 | <input type="checkbox"/> \$2,000/\$4,000 |
| <input type="checkbox"/> \$2,250/\$4,500 | <input type="checkbox"/> \$2,500/\$5,000 | | |

- Plan I** _____ **Plan II** _____

Application To:
Fidelity Security Life Insurance Company
3130 Broadway, Kansas City, MO 64111-2406

**FOR GROUP SUPPLEMENTAL
 MEDICAL EXPENSE INSURANCE**

Gap360

APPLICANT INFORMATION:

Name (last, first, middle)				Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Age	Date of Birth (mm/dd/yy)	Social Security Number	Home Phone #	Work Phone #	
Street Address			E-Mail		
City		State	Zip Code		
Employer		Occupation	Date of Hire		
Coverage Selected: <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Employee & Family					
Monthly Premium: \$		Requested Effective Date of Coverage/Change:			

DEPENDENT INFORMATION

	Name (last, first, middle)	Birth Date	Sex	Social Security #
Spouse				
Child				
Child				
Child				

(Use reverse side of form if additional space is needed)

I hereby: **ENROLL**, or **CHANGE** as indicated above, for this group insurance coverage for which I am eligible. I authorize my Employer to deduct my contributions, if any, from my salary or wages, and to remit that amount to Fidelity Security Life Insurance Company. I request that this authorization remain in effect until such time as I withdraw it by giving written notice prior to the next premium due date. I understand and acknowledge: That no coverage will take effect for any person to be covered who is not also covered by a Major Medical/Comprehensive Policy including Coinsurance and Deductible, in force at the time of my proposed Effective Date for this coverage; that I and any of my dependents to be insured, are either currently covered under a Major Medical/Comprehensive coverage with this Employer or have enrolled for Major Medical/Comprehensive coverage with this Employer, and that the coverage for which I am applying may contain Pre-Existing Limitations. I will receive a certificate as evidence of my insurance coverage under the policy. **The Certificate provides limited benefits. Review your Certificate carefully.**

Applicant's Signature _____ Date _____
 Parent or Legal Guardian if the Applicant is Under Age 18

Agent's Signature _____
 (where applicable by law)