



The effective date of this insurance applied for will be the later of the first day of the month following the acceptance of employee Enrollment Forms by the Company and receipt of premium payment, or the Employee's effective date under the Employer's Major Medical/ Comprehensive coverage.

Requested effective date for group: \_\_\_\_\_

New employees are eligible the first of the month following employment.

I understand that requests submitted to the Company for individual employee cancellation of coverage and return of premium, if any, must be signed by the employee. **The Policy provides limited benefits. Review your Policy carefully.**

Signature of Employer \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Contact Person \_\_\_\_\_ Daytime Telephone No. \_\_\_\_\_

**EMPLOYER AUTHORIZATION**

**A. ELECTRONIC FUNDS TRANSFER:**

I wish to have my monthly premium deducted from the checking account number shown on the attached check (PLEASE SEND VOIDED CHECK). I authorize my bank to withdraw the appropriate premium on a monthly basis. I understand that, if I wish to discontinue this authorization or my checking account number changes, I will notify in writing Fidelity Security Life Insurance Company.

Signature of Depositor \_\_\_\_\_  
(as it appears on checking account)

**B. DIRECT BILL:**

Organization/Firm \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
(If different from the first page)

Employer's Signature \_\_\_\_\_

**AGENT INFORMATION:**

Writing Agent Name \_\_\_\_\_

Agent Address \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Tax ID No. (If none, Social Security No.) \_\_\_\_\_

Commission Paid To \_\_\_\_\_

Are you appointed with Fidelity Security Life Insurance Company?  Yes  No  
If "No", contact Fidelity Security Life Insurance Company immediately regarding appointment.

