If List Billing	Fidelity Security Life Insurance Company 3130 Broadway • Kansas City, MO 64141	Agent Name (Please Print) Tom Agent
Company Name	**APPLICATION FOR INSURANCE** **USE DARK INK**	Agent # 999999
Billing Number ISMA01M		#

Proposed Primary Insured

Name First	Middle	Last	Age	Date of Birth	Birth Place	Height	Weight	Social Security #
John		Doe	30	02/08/1991	Orange	6' 4"	225	876-54-3210

☑ Male ☐ Female ☐ Married ☑ Single ☐ Widowed ☐ Divorced ☐ Separated

Home Address	City	State	Zip Code	Home Phone No.
1234 Disney Way Lane	Anaheim	CA	92866	(714) 505-1100

Employer Name and Address	Occupation	Employer Phone No.	How Long
ABC Co. 1122 Main St. Orange, CA 92788	Sales	(714) 555-5555	8 Years

Secondary Insured(s) Who are applying for 10 Year Term Life Insurance Benefit Rider

Name (First, Middle, Last)	Relation to Primary Insured	Sex	Social Security Number	Occupation	Date of Birth	Age	Birth Place	Ht.	Wt.

Owner Information

Owner's Name (if other than Proposed Insured)	Social Security No.	Relation to Proposed Primary Insured

Owner's Address	City	State	Zip Code

Beneficiary

Primary James Doe Relationship Father Date of Birth 07/07/1960 Phone No (714) 505-1100
Address 1234 Disney Way Lane Social Security or Tax ID No 777-44-3333

Contingent _____ Relationship _____ Date of Birth _____ Phone No _____
Address _____ Social Security or Tax ID No _____

Coverage and Benefits for Primary Insured

GROUP LIFE INSURANCE PLAN: TL-68 ☑ Term to 100, Modified Premium Certificate ☐ 10 Year Term Certificate ☐ Other

		Premium
GROUP LIFE INSURANCE PLAN FACE AMOUNT $ MP		$ 1,200.00
RIDERS (Only Available with Term to 100 Modified Premium Group Life Insurance Plan):		
☐ Accelerated Death Benefit		$
☐ Accidental Death Benefit	*Face Amount* $	$
☐ Additional Purchase Option Benefit	*Face Amount* $	$
☐ Flexible Premium Annuity Benefit		$
☐ 10 Year Term Life Insurance Benefit	*Face Amount* $	$
☑ Monthly Disability Income Benefit	*Monthly Benefit Amount* $ 110	$
☐ Waiver of Premium for Total Disability		$
☐ Waiver of Premium for Flexible Premium Annuity Due to Total Disability		$
☐ Critical Illness Benefit	*Benefit Amount* $	$
☐ Child Rider	*Face Amount* $	$
PRIMARY INSURED'S TOTAL PREMIUM:		$ 1,200.00

Coverage for Secondary Insured(s)

10 Year Term Life Insurance Benefit Rider — Premium

Name _____ Face Amount $ _____ $ _____
Name _____ Face Amount $ _____ $ _____
For additional names and amounts, please attach a separate sheet which is signed and dated.
SECONDARY INSURED(S) TOTAL PREMIUM: $ _____

Premiums and Payment Method

TOTAL PREMIUM (ALL INSUREDS): $ 1,200.00

Premium Mode: ☐ Annual ☐ Allotment ☑ Monthly Pre-Authorized Check (PAC) **(Attach Authorization and Void Check)** ☐ List Bill (Minimum of 3)

Automatic Premium Loan? ☑ Yes ☐ No

Send Premium Notices to: ☑ Insured ☐ Owner ☐ Other (Please attach a separate sheet with with name and address)
Name: Address:

Requested Effective Date: 04/01/2021

Conditional Receipt Given? ☐ Yes ☑ No

Amount Collected: $ 0.00

Life Insurance in force for all Proposed Insureds

Insured	Name of Company	Benefit/Face Amount	Issue Year	Policy Type

Will the insurance coverage applied for replace or change any existing insurance or annuity contract? ☐ Yes ☑ No
If yes, which company? _____ Policy No.: _____ Termination Date: _____

Has any proposed insured person ever had a driver's license revoked or suspended? ☐ Yes ☑ No
Name: _____ Driver's License Number: _____

Has any proposed insured person used tobacco in any form in the past 12 months? ☐ Yes ☑ No
If yes, name: _____ What form? _____ How frequently? _____

Has any proposed insured person ever participated or do any anticipate participation in the next two years:
a. as a pilot, student pilot, or member of the crew of any type of aircraft? ☐ Yes ☑ No
b. in sky diving, parachuting, underwater diving, racing? ☐ Yes ☑ No
(If yes to either question, please complete and attach Form A-00916)

Has any proposed insured person ever had life, disability, or health insurance coverage declined, restricted, postponed, rated up, or charged an extra premium for such insurance? ☐ Yes ☑ No
If yes, give details: _____

A-00904(07/03) **SPECIAL REQUESTS** **ADMINISTRATIVE OFFICE USE** M-1031 Rev. 08/17

Conditional Receipt --- Do Not Detach Unless Full First
Premium Is Paid With Application

The term "policy" shall mean "certificate" where coverage is issued on a group policy. No insurance will become effective prior to policy delivery, until each and every condition contained in this receipt is met. No agent or broker of Fidelity Security Life Insurance Company ("the Company") is authorized to alter or waive any of the following conditions.

Received from _____ the sum of $_____ this _____ day of _____, 20____ for the full first premium specified in the application for life insurance with the Company which bears the same date as this receipt. Agent Name _____ Agent Signature _____

This receipt is not valid unless it is signed by an agent of the Company.

The conditions under which insurance, for which payment as described above is intended, may become effective prior to delivery are as follows:

1. The Proposed Insured(s) may be, on the Effective Date as hereafter defined, a risk acceptable to the Company under its rules, standards and practices for the exact policy and premium applied for, without any modification.
2. The amount of payment taken with the application must be equal to the amount of the full first premium according to the mode of premium payment selected.
3. The policy is issued exactly as applied for within 60 days from the date of application.

If each and every one of the above conditions shall have been fulfilled, then insurance as provided by the terms and conditions of the policy applied for will become effective, prior to policy delivery. If the Optional 10 Year Term Insurance Rider is applied for and the above conditions are met for such insurance except that one or more Proposed Secondary Insured(s) to be covered are not insurable under the Company's rules for such insurance, the Optional 10 Year Term Insurance Rider for which the other persons to be covered are insurable under the Company's rules, shall be effective as provided above. The total amount of insurance (life insurance and any accidental death benefits attached thereto as a rider) which may become effective prior to the policy delivery shall not exceed $75,000 per Proposed Insured.

Definition of "Effective Date":
Means the later of: (a) the date the application is signed; (b) the date of completion of all medical examinations, if required; or (c) the Requested Policy Date shown on the application.

If one or more of the conditions is not met, the liability of the Company will be limited to the return of the sum received. This receipt will be void if given for a check or draft which is not honored on presentation.

All premium checks must be made payable to the Company or ISM Administrators: Do not make check payable to the agent or leave the payee blank.

Applicant Signature_____

Has any proposed insured person:	Yes	No
1. Within the past 10 years, had a diagnosis of or been treated for cancer, tumor, cyst, heart or circulatory trouble, high blood pressure, stroke, anemia, blood disorders, diabetes, thyroid, glandular disorder, psychiatric conditions, neurological impairment, digestive system, liver, kidney, respiratory disorders, asthma, emphysema, chronic obstructive lung disease, muscular or skeletal system, alcohol or drug abuse?	☐	☑
2. Within the past 10 years, been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☑
3. Currently or been under a doctor's care or taking any prescribed medication?	☐	☑
4. During the past 5 years, consulted any physician or other practitioner, been hospitalized, had a blood study, or an operation?	☑	☐
5. Ever used drugs or similar agents other than as prescribed by a physician?	☐	☑
6. Ever had surgery or has surgery ever been recommended?	☐	☑
7. Had any physical or mental defect, including depression or nervousness, other than shown above?	☐	☑
8. Gained or lost weight in the past year? If yes, give amounts and cause below.	☐	☑
9. If applying for the Critical Illness Benefit, please answer the following: Have any of your parents, brothers, or sisters suffered from, or died of, heart disease, stroke, cancer, diabetes mellitus, kidney disease or paralysis prior to age 60?	☐	☑

Name and address of regular physician for each proposed insured person: Dr. James Brown 1111 Holiday Lane Laguna Beach, CA 92888
(949)888-1111

If you answered "Yes" to any of the above questions, give complete details below. If additional space is needed, please attach a separate sheet which is signed and dated.

Q#	Person to Whom it Applies	Date of Service	Include all information as to the nature of illness or injury, symptoms, duration, treatment, and results.	Name and Address of Physician(s) and Hospital(s), if any.
4	John	10/10/2020	Routine Physical - Results Normail	Dr. James Brown

I and the undersigned agent represent that all statements and answers contained in this application are complete and true. I AGREE that this application will be the basis for and part of the Certificate that is issued; and that coverage will begin on the effective date in the Certificate if the first premium has been paid during the proposed Insured's lifetime and while his/her health and occupation remains as stated on this application. I understand any material misstatements or omissions may be used as a basis for rescinding my coverage. This means all claims will be denied and the Company's liability will be limited to full refund of premium less any claims previously paid. I and the undersigned agent certify that I have read, or had read to me, the completed application.
Coverage may begin prior to the date of delivery of the Certificate as shown in the Conditional Receipt. Any life benefits effective prior to the Certificate delivery date are limited to $75,000. This limit includes any accidental death benefits attached to the Certificate.

I have received and read a copy of the Pre-Notice which describes how information is obtained and used by Fidelity Security Life Insurance Company.

I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, Inc. (MIB), IntelliScript, or other organization or institution that has any records or knowledge of me or my dependents' physical or mental health, including significant history, findings, diagnoses and treatment or nonmedical information, such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications of insurance, to give to Fidelity Security Life Insurance Company, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my applications 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 or have applied for with Fidelity Security Life Insurance Company.

Fidelity Security Life Insurance Company or its authorized representatives may release to its plan administrators, business associates, other insurance companies, MIB, or others whom I authorize in writing, information covered by this authorization. I authorize Fidelity Security Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

I agree this authorization shall be valid for two years from the date shown below.

I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64141-8131, Attention: Privacy Officer. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Fidelity Security Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand I will receive a copy of this authorization.

No agent can: a) accept risks; b) modify coverage; or c) waive any rights or requirements. The acceptance of any Certificate issued on the basis of this application shall be an acceptance and ratification of all corrections, additions, or changes noted in the "Administrative Office Use" section on the front of this application. However, any change in the amount, class, plan of insurance, benefits, or the age at issue shall be subject to written agreement by the applicant.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

X John Doe 03/11/2021
Signature of Proposed Insured Date

X
Signature of Proposed Secondary Insured (if an adult) Date

X
Signature of Owner Applicant Date

X
Signature of Proposed Secondary Insured (if an adult) Date

X Tom Agent 03/11/2021
Signature of Licensed Agent Date

X
Signature of Parent or Legal Guardian of Proposed Secondary Insured (if Proposed Secondary Insured is a minor) Date

03/11/2021 Anaheim CA 012345
Dated City State Agent's State License No

Agent Information

Is Proposed Insured's Certificate to be sent to the Agent? ☑ Yes ☐ No

Writing Agent Statement

I hereby attest that I: 1) have personally seen the person proposed for insurance at the time this application was completed; 2) have personally asked each question on the application of the person proposed for insurance, and to the best of my knowledge and belief the statements contained in the application are complete and true; 3) have personally witnessed the signature of the person proposed for insurance; 4) have viewed the photo ID belonging to the proposed insured and that it is a valid ID, and the proposed insured's signature affixed above is consistent with the signature on the photo ID.

To your knowledge and belief, will the insurance coverage applied for replace or change any existing insurance or annuity contract? ☐ Yes ☑ No

If yes, which company? _____ Policy No.: _____ Termination Date: _____

Agent's Signature X Tom Agent Commission % 100%

Agent No. 999999 Dated at Anaheim this 11 day of March, 20 21

2nd Agent's Signature X _____ Commission % _____

Agent No. _____ Date _____

PRE-NOTICE

Although your application is our main source of information, we at Fidelity Security Life Insurance Company may also collect or verify information pertaining to age, occupation, physical condition, health history and avocations by contacting various individuals or organizations by correspondence, telephone or personal contact. It may be necessary for us to share information we obtain with an individual or organization related to the medical or insurance industry or with an individual performing a function for us without your express written authorization.

Information regarding your insurability will be treated as confidential. Fidelity Security Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply each company with the information about you 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 (TTY 866-346-3642). If you question the accuracy of 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 MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Fidelity Security Life Insurance Company or its reinsurers may also release information from 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

SERVICE AGREEMENT

ADMINISTERED BY: ISM ADMINISTRATORS | 17722 IRVINE BOULEVARD, TUSTIN, CA 92780 | 800-488-1474 | FAX: 714-505-1111 | AmericanAssociations@husmail.com

1) DEPOSITOR'S NAME ☑ INDIVIDUAL ☐ BUSINESS Last Doe First John M.I.	8) NAME OF BANK Chase	12) CHECK THE MO. PAYMENT DATE REQUESTED (Default date is 15th) ☐ 1ST ☑ 15TH ☐ 20TH ☐ ANNUAL PAYMENT
2) INSURED NAME John Doe	☐ SAVINGS ☑ CHECKING	13) SERVICE FEE 5
3) INSURED ADDRESS 1234 Disney Way Lane	9) ACCOUNT NO. 12345678	14) NET MODAL PREMIUM/PAYMENT 100
4) CITY, STATE, ZIP Anaheim, CA 92866	10) ROUTING NO. 031000111	15) ASSOCIATION: ☑ AAPE ☐ AAGE Mo. Dues: $ 5
5) DAY TIME PHONE NO. (714)505-1100 / 6) EVENING PHONE NO.	11) BANK PHONE NO.	16) OTHER: _____ Amount: $
7) EMAIL ADDRESS **(REQUIRED)** jdoe28@gmail.com		17) OTHER: _____ Amount: $
Banking Information (Items 8-11 above) are not necessary if paying by credit card. I authorize the credit card charge of my payments and related fees to my: ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex Card No. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Exp. Date ____/____ Security Code _____		**18) TOTAL: $** 110

The above-named individual (hereafter referred to as "Client") requests ISM Administrators, ("ISMA"), to provide the services described below, under the Terms and Conditions outlined in this Service Agreement ("Agreement"), in return for a periodic Service Fee identified above and agreed hereto.

SERVICES

The Client shall receive the following services from ISMA: The effectuation of the payment of monies, or deposits, to designated third parties as requested or otherwise directed in writing by Client. In exchange for providing the services for Client, ISMA is entitled to a monthly Service Fee as designated above. **The Fee is earned following the performance of the monthly service and is not refundable.** ISMA may, from time to time, in its discretion, modify the Service Fee upon thirty (30) days written notice to Client.

In order to receive the above services, Client hereby authorizes their above-named institution to accept periodic electronic transfers or drafts from the Bank's Automated Payment Service for the amount stipulated above or as modified in writing from Client in the frequency stipulated above. Said transfers shall continue subject to the Terms and Conditions of the Agreement.

AUTHORIZATION FOR AUTOMATIC TRANSFER OR PROCESSING OF PAYMENTS: (NOT APPLICABLE TO ANNUAL PAYMENT)

I/we hereby authorize the transfer of funds held in the above-named institution for the purpose of making monthly payments for non-insurance products or services on my behalf. I/we further authorize ISMA to effectuate payment processing for insurance premiums due with funds held in the above-named institution. I/we authorize the above-named institution to effectuate transfer or processing of funds as if the transaction were signed personally by me/us. This authority is to remain in effect until I/we revoke same in writing, and I/we agree that each institution involved in any transfer shall be fully protected in honoring such transfers until such time. I/we further agree that if any transfer is dishonored due to any reason, the institutions involved shall be under no liability whatsoever. In addition, I/we authorize ISMA to reverse any payment processed on my behalf if my transfer is dishonored for any reason. In the event that an erroneous electronic transaction is posted to my account, ISMA may execute a reversal of that transaction.

I authorize ACH payment of initial premium in lieu of credit card if not included with my application.

Anti-Money Laundering regulations imposed by the federal government as part of the Patriot Act prohibit the payment of insurance premiums by cashier's check or money order.

TERMS AND CONDITIONS

Client may terminate this Agreement at any time giving ISMA thirty (30) days written notice. ISMA may choose to terminate this Agreement if for any reason a debit transfer from Client's above-named institution cannot be made. In the event of an EFT or credit card charge that is not honored by the Client's above-named institution for payment of non-insurance premiums, for any reason, a service charge will be imposed on the client. The amount of the service charge will be the standard fee then in effect, which is subject to modification by ISMA from time to time in its sole discretion. Client acknowledges that, in the event a debit transfer is unsuccessful for the reasons stated above, any payments processed on the Client's behalf to any institution will not be made until Client satisfies the unsuccessful debit plus all related fees. Should ISMA choose to terminate this Agreement due to occurrence of unsuccessful debit transfer, the Client will forfeit any right to a refund of any fees paid to date, without release of obligation on monies still owing to ISMA, or its custodian. Client agrees that any monies owed to ISMA, or its custodian, shall be subject to any additional charges and costs incurred by ISMA, or its custodian, through collection procedures, legal fees, and court costs. In the event that the parties must litigate disagreements arising from this contract, the parties agree to conduct any such litigation under the laws of the State of California, and that venue for such proceedings shall be only in the County of Orange, State of California.

Client agrees that any late fees, adverse credit reports to any credit reporting agency, loss of coverage, or loss of interest/gain on any capital accumulation account due to inaccessible or insufficient funds in the Client's account are the sole responsibility of the Client.

Client agrees that ISMA, the custodian, and all recipients of directed or processed payments shall not be liable for any loss occasioned by inadvertent delay or error in remitting monies to the institution or designated account, nor shall such companies bear any responsibility for any security transactions effectuated on behalf of Client by a third party. Client agrees that electronic processing or drafts prior to policy approval and issue, if applicable, do not constitute, imply or guarantee the issuance of insurance coverage. Client agrees that the policy/certificate is considered to be delivered and placed when premiums have been successfully processed as authorized by this Agreement in excess of three (3) uninterrupted or non-disputed months from the effective date of coverage. In the case of Annual Payment, Client agrees that the policy/certificate is considered to be delivered and placed when premium has successfully processed as authorized by this Agreement and three (3) non-disputed months have elapsed. Client understands that ISMA is solely a processor or administrator of Client's monies and contracting with ISMA does not require the purchase of any other services.

IT IS THE CLIENT'S RESPONSIBILITY TO NOTIFY ISMA IN WRITING, THIRTY (30) DAYS PRIOR TO THEIR NEXT PAYMENT OF ANY CHANGE OF ADDRESS, BANK ACCOUNT NUMBER, CHANGE OF BANK, PAYMENT AMOUNT, OR PAYMENT METHOD. FAILURE TO DO SO MAY RESULT IN AN UNSUCCESSFUL PAYMENT PROCESS TO INSURER, CAPITAL ACCUMULATION ACCOUNT, ASSOCIATION OR OTHER BENEFIT. ALTHOUGH ISMA MAY CONTINUE TO PROCESS OR DRAFT WHEN YOU HAVE MISSED A PAYMENT, YOUR COVERAGE MAY NOT BE IN FORCE IN THE EVENT OF A CLAIM AGAINST YOUR POLICY. IT IS THE CLIENT'S RESPONSIBILITY TO NOTIFY ISMA IN WRITING IF THE POLICY/CERTIFICATE IS NOT RECEIVED. FAILURE TO CONTACT ISMA IN A TIMELY MANNER MAY BE CONSTRUED AS RECEIPT OF THE POLICY/CERTIFICATE.

If any one or more of the provisions and/or conditions contained in this Agreement shall be held invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision of this Agreement. This is the parties' entire agreement as pertains to this Service Agreement, superseding all previous oral or written agreements, representations, or express or implied warranties.

I/we have read, and agree to, the Terms and Conditions as stated above.

DEPOSITOR (SIGNATURE	OWNER IF OTHER THAN DEPOSITOR (SIGNATURE)	DATE
John Doe		3/11/2021

ORIGINAL: TO HOME OFFICE / COPY: TO CLIENT

ISM ADMINISTRATORS
ACKNOWLEDGMENT

I acknowledge that all applicants must be members of either the American Association of Government Employees (AAGE) or the American Association of Private Employees (AAPE). One Member per immediate family is required, and association dues are $1.00 per month. First month's dues must be submitted with this Acknowledgment, payable to ISM Administrators.

Check one: _____AAGE _X_AAPE

As part of my Association benefits, I have applied for a Modified Premium Term to Age 100 Life Insurance Policy/ Certificate with Flexible Premium Deferred Annuity Rider, underwritten by Fidelity Security Life.

I understand that I have the *option* to stop premiums and/or coverage after ten years, or continue premiums and/or coverage for a longer period.

I acknowledge and understand that:

1. The annual premium payable for the first policy/certificate year includes an *additional first year premium*.
2. If I elect to discontinue premium on the policy/certificate the *additional first premium* will be forfeited and the only benefit available to me will be as set forth in the non-forfeiture provisions of the policy/certificate. Such benefit may be less in value than the *additional first year premium*.
3. I may experience a monetary loss if the policy/certificate is discontinued before non-forfeiture values become available.
4. The cash value under this policy/certificate arising from the *additional first year premium* will be at least 260% of the *additional first year premium* at the end of the 10th year.

I understand that starting in the second year, part of my premium (an amount equal to the *additional first year premium*) will commence going into the Flexible Premium Deferred Annuity Rider. I understand that I may stop premium from going into my Flexible Premium Deferred Annuity Rider, and redirect it to a separate non-insurance cash accumulation vehicle of my choice by providing written notification to ISM Administrators.

I understand that ISM Administrators will send me a reminder letter near the end of my first year. The letter is a service provided to me, and is *not* an advisory or solicitation to buy any particular investment. The letter will remind me that:

A. I can have premium go to my Flexible Premium Deferred Annuity Rider with the insurer.
B. I can redirect the Annuity premium to a separate non-insurance vehicle.
C. I can take a combination of both.

I understand that "A" shall be automatic should I fail to respond to the letter. I understand that if I elect "B" or "C", I will be in direct contact with a registered investment company that is separate from, and not connected with, the insurer or ISM Administrators.

I understand that I may increase my cash accumulation contribution annually to accommodate cost of living increases, thereby adding to its growth.

❑ Please automatically increase my monthly draft by _____% or $ _____ on each plan anniversary.
☑ I will notify ISMA in writing of any contribution increases I wish to make.

I understand that ISM Administrators will adjust my premium payments according to my written instructions, and that I can modify instructions annually in writing. I understand that should I die, my beneficiary will receive the face amount of my policy/certificate PLUS any value in my cash accumulation vehicle PLUS, if this occurs during the first ten years that my life insurance is in force, the fully matured value of the additional first year premium.

I acknowledge that I may be applying for a separate product, service, and/or Association membership through the undersigned representative. I understand that the insurance plan may not be connected with the above mentioned separate Association membership and/or any other products or services applied for through the undersigned representative. By signing below, I agree to receive all documents and correspondence electronically and that I can access the Internet or the email address provided. I understand that I may revoke this authorization, or request specific paper documents without revoking this authorization, by contacting ISM Administrators by mail or email.

John Doe	John Doe	3/11/2021
Signature of Proposed Insured or Owner (circle one)	Printed Name of Proposed Insured or Owner	Date
Signature of Owner (If Other Than the Insured)	Printed Name of Owner	Date
Tom Agent	Tom Agent	3/11/2021
Signature of Agent	Printed Name of Agent	Date

17722 Irvine Boulevard • Tustin, California 92780 • (800) 488-1474
www.AmericanAssociations.org

Fidelity Security Life Insurance Company

3130 Broadway, Kansas City, Missouri, 64111

LIFE ILLUSTRATION ACKNOWLEDGEMENT

Check The Applicable Box Below

This Form Must Be Submitted With The Application

☐ I have been presented an illustration for a life insurance policy/certificate, *but I have applied for coverage other than as illustrated.* Therefore, an illustration conforming to my application is not being left with me at this time. An illustration conforming to the policy/certificate as issued will be provided at the time of delivery.

☑ *I have applied for a life insurance policy,/certificate but the Agent has not provided an illustration.* Therefore, no illustration is being left with me at the time of application. An illustration conforming to the policy/certificate as issued will be provided to me at the time of delivery.

☐ *Check only this box if a computer screen illustration was viewed.* I acknowledge that I viewed a computer screen illustration based on the information as stated below. No hard copy of the illustration is being left with me at this time. An illustration conforming to the policy/certificate as issued will be provided to me at the time of delivery.

Agent Certification When Using A Computer Screen Illustration

I certify that I displayed a computer-screen illustration of TL-67/TL-68
(policy/certificate & Rider Marketing Name)
that complies with state requirements and for which no hard copy was furnished.

- Gender Male
- Age 30
- Underwriting or Rating Class _____
- Generic Name of policy/certificate TL-67/TL-68
- Initial Death Benefit MP

The Agent and Applicant Must Sign Where Indicated

Tom Agent 3/11/2021	John Doe 3/11/2021
Agent Signature/Date	Applicant Signature/Date
Tom Agent	John Doe
Agent Name - typed or printed	Applicant Name - typed or printed

AG/LIACK (1/99) 70AP-3

White - Home Office Yellow - Applicant

ACCELERATED DEATH BENEFIT DISCLOSURE STATEMENT

The Policy/Certificate you have applied for or that has been issued to you contains benefits in the form of a Rider that is attached and allows you to receive an accelerated payment of death benefits. Consult your Policy/Certificate for details.

Accelerated Death Benefits means benefits payable under the Policy/Certificate in anticipation of death from a Terminal Medical Condition.

Accelerated Death Benefit Amount means the amount the Owner requests according to the Rider. The amount will be adjusted, as stated in the Benefit section.

Administrative Expense Charge means the amount deducted from the Accelerated Death Benefit Amount to pay the cost of processing the acceleration of Death Benefits according to Our current practice at the time the benefit is requested. In no event will the charge exceed $200.

Immediate Family means a spouse, grandparent, parent, brother, sister, or child related by blood or marriage to the Insured, in-law, or any person who resides with the Insured.

Physician means a person licensed by the state in which he or she resides to practice the healing arts. He or she must practice within the scope of his or her license for the service or treatment given. He or she cannot be the Insured or a member of the Immediate Family.

Physician's Statement means a written statement signed by a Physician which: 1) gives the Physician's diagnosis of the Insured's Terminal Medical Condition; and 2) states that, with reasonable medical certainty, the Terminal Medical Condition will result in death within 12 months or less from the date the statement is signed.

Terminal Medical Condition means a medical condition that with reasonable medical certainty, will result in the death of the Insured within 12 months or less from the date of the Physician's Statement. The condition must be diagnosed by a Physician on or after the effective date of the Rider, while the Rider is in force.

Tax Disclosure Statement: An Accelerated Death Benefit received under provisions of group life insurance coverage may be taxable to the recipient (and assistance should be sought from a personal tax advisor); and/or, may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlement.

Benefit
If the Insured is diagnosed with a Terminal Medical Condition, the Owner may request an acceleration of a portion of the Death Benefit of the Policy/Certificate (Accelerated Death Benefit Amount). Payment of a benefit under the Rider will be made only once while the Insured is covered under the Policy/Certificate.

Reduction of the Accelerated Death Benefit Amount
1. If the Death Benefit is scheduled to reduce in the 12 months following the date the Company approves the request, the Accelerated Death Benefit Amount will be reduced proportionately.
2. An actuarial discount is deducted, which reflects the early payment of the Death Benefit.
3. A one time Administrative Expense Charge not to exceed $200 is deducted (currently $100).
4. Any outstanding loan is adjusted by repaying a portion of the loan from the Accelerated Death Benefit Amount.
5. Any premium due will be paid from the Accelerated Death Benefit Amount.

Effect of Rider Benefit on Policy/Certificate
After payment of an Accelerated Death Benefit, the Policy/Certificate stays in force, but is changed as follows:

1. The Death Benefit is reduced.
2. Any guaranteed and current cash value, any outstanding loan and any required premium are reduced in the same proportion as the reduction in Death Benefit.
3. If there is a Waiver of Premium coverage in force, the Insured is deemed to be Totally Disabled and the initial waiting period required by such coverage is satisfied.

ACCELERATED DEATH BENEFIT DISCLOSURE ACKNOWLEDGMENT

I acknowledge receipt of the Accelerated Death Benefit Disclosure Statement form, which describes additional benefits attached to the Policy/Certificate I am applying for:

John Doe		Tom Agent	3/11/2021
Signature of Applicant	Signature of Owner	Signature of Agent(if present)	Date