

New Enrollment Re-enrollment Plan _____

SECTION 1 - PARTICIPATING ENTITY

Name of Participating Entity: _____

SECTION 2 - APPLICANT

Date of Hire: _____ Location/Dept.: _____ ID#: _____

Applicant (Give Full Legal Name) _____ Female Male Soc Sec # _____

Birth Date MM/DD/YYYY Age _____ Have You Used Tobacco or Nicotine Products in the Last 12 Months? Yes No Phone # _____

Current Legal Residence Applicant/Spouse/Domestic Partner _____ City _____ State _____ ZIP _____

SECTION 3 - SPOUSE/DOMESTIC PARTNER APPLICANT INFORMATION - ONLY NEEDED IF APPLYING FOR SEPARATE COVERAGE

Full Legal Name _____ Female Male

Birth Date MM/DD/YYYY Age _____ Have You Used Tobacco or Nicotine Products in the Last 12 Months? Yes No

SECTION 4 - ELIGIBILITY QUESTIONS

	Applicant	Spouse/Domestic Partner
Is the proposed Insured a United States Citizen or have a Permanent Resident Status?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the employee actively at work and performing the regular duties of his/her job in the usual manner and at the usual place of employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION 5 - COVERAGE APPLIED FOR

Applicant	Spouse/Domestic Partner
Face Amount: \$25,000 <input type="checkbox"/> : \$50,000 <input type="checkbox"/> Decline <input type="checkbox"/>	Face Amount: \$25,000 <input type="checkbox"/> : \$50,000 <input type="checkbox"/> Decline <input type="checkbox"/>
Rider Options: WP <input type="checkbox"/> : ADB <input type="checkbox"/> : Child Term \$10,000 <input type="checkbox"/> : \$25,000 <input type="checkbox"/>	Rider Options: PWP <input type="checkbox"/> : ADB <input type="checkbox"/> : Child Term \$10,000 <input type="checkbox"/> : \$25,000 <input type="checkbox"/>
LTC <input type="checkbox"/> : EOB <input type="checkbox"/> : Spouse/Dom Partner Level Term <input type="checkbox"/> \$ _____	LTC <input type="checkbox"/> : EOB <input type="checkbox"/> : Spouse/Dom Partner Level Term <input type="checkbox"/> \$ _____
Other <input type="checkbox"/> : _____	Other <input type="checkbox"/> : _____
Premium Mode: Wkly <input type="checkbox"/> Bi-Wkly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Other <input type="checkbox"/>	Premium Mode: Wkly <input type="checkbox"/> Bi-Wkly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Other <input type="checkbox"/>
Total Premium Per Pay Period \$ _____	Total Premium Per Pay Period \$ _____

SECTION 6 - BENEFICIARY INFORMATION

The Applicant will be the Beneficiary of any coverage issued on a Spouse or Child, unless otherwise stated in this section. The Spouse will be the Beneficiary of any coverage issued on the Applicant, unless otherwise stated in this section.

Primary Beneficiary – Applicant	Relationship	Primary Beneficiary – Spouse/Domestic Partner	Relationship

SECTION 7 - MODIFIED CONDITIONAL GUARANTEED ISSUE

	Applicant	Spouse/Domestic Partner
1. Has the Applicant missed more than 5 consecutive days of active work due to an illness or injury in the past 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A
2. Has proposed insured been hospitalized overnight for 48 or more consecutive hours in the past 6 months for anything other than pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any proposed Insured, within the last 10 years, been diagnosed as having or been treated by a physician for HIV infection, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has proposed insured been seen or treated by a licensed physician or medical practitioner within the last 6 months for anything other than common cold, flu, pregnancy, routine physical or routine visit with normal results?	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 8 - DECLARATION AND AGREEMENT — PLEASE READ THE FOLLOWING, THEN SIGN AND DATE BELOW BEFORE MAILING

I/We declare that each answer given to the questions contained in this enrollment form is complete and true to the best of my/our knowledge and belief. I/We understand and agree that the company will rely on these answers, and the answers and statements I/we may give in any other form taken as part of this enrollment form. I/We also understand that the Company reserves the right to accept or deny this enrollment form after taking into account whatever information may be available to it, including availability as to coverage by its reinsurers. All statements and answers on this enrollment form are full, complete and true to the best knowledge and belief of each person who has signed below. I understand that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage will be provided upon delivery of the certificate of coverage. **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 enrollment form for insurance may be guilty of criminal offense under state law.

Applicant Signature: _____	Date MM/DD/YYYY _____
Spouse/Domestic Partner Signature: _____	Date MM/DD/YYYY _____



Established 1896

Fidelity Life Association, A Legal Reserve Life Insurance Company
Administrative Office: P.O. Box 506
Keene, NH 03431-0506

Supplement to Group Enrollment Form

Insured Name: _____
Please Print

Applicant SSN: _____

This Supplement to the Group Enrollment Form for Life Insurance is required to be completed when an applicant or spouse applies for the Optional Accelerated Benefit for Long Term Care

Table with 4 rows of questions and 4 columns for Applicant (Yes/No) and Spouse (Yes/No). Questions include: 1. Does the Applicant or Spouse have any other long term care insurance... 2. Did the Applicant or Spouse have any long term care insurance policy... 3. Are you covered by Medicaid? 4. Do you intend to replace any of your medical or health insurance coverage...

Table with 5 columns: Applicant or Spouse, Name of Company, Face Amount, Month/Year Issued, To be Replaced? (Yes/No). It contains two empty rows for data entry.

SECONDARY ADDRESSEE:

As required by State law, an insurer issuing Long Term Care Coverage is required to notify the applicant of the right to designate at least one additional person to receive notification of a possible lapse or termination in coverage. Notice will be provided to any secondary addressee 30 days after a premium is due and unpaid. This constitutes our notification to you of your right to designate such an addressee. If you wish to designate a secondary addressee, please do so by complete the following:

Designation of Secondary Addressee:

Secondary Addressee (Give Full Legal Name): _____

Mailing Address: _____
Street City State Zip

Signature _____

Date _____

**IMPORTANT NOTICE ABOUT THE
POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED**

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS

READ THE FOLLOWING INFORMATION CAREFULLY.

1. The Coverage for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this Coverage must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the position of the parties.
5. When you accept this insurance coverage you agree to resolve any disagreement related to the Coverage by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the Certificate, I should read the arbitration clause contained in the Optional Benefit and that I have the right to reject this Optional Benefit within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that Coverage related disagreements be resolved by binding arbitration.

Applicant/Insured

Date

Time

Agent

Date

Time