

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: _____

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.

Signature of Employer _____ Title _____ Date _____

Contact Person _____ Daytime Telephone No. _____

EMPLOYER AUTHORIZATION

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.