

PLAN INFORMATION:

As selected by the Policyholder

In Hospital Benefit Amounts

- Plan I: \$ _____ In-Hospital Benefit
- \$ _____ Optional Out-Patient Benefit: OPI OPII
- \$ _____ Optional Physician Benefit Rider
- \$ _____ Optional Wellness Rider

- Plan II: \$ _____ In-Hospital Benefit
- \$ _____ Optional Out-Patient Benefit: OPI OPII
- \$ _____ Optional Physician Benefit Rider
- \$ _____ Optional Wellness Rider

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

FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE

SISLink™

Arranged by:
Special Insurance Services, Inc.
6509 Windcrest Drive, Suite 200
Plano, TX 75024

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 Only		<input type="checkbox"/> Employee & Spouse		
		<input type="checkbox"/> Employee & Child(ren)		<input type="checkbox"/> Employee & Family		
Monthly Premium:			Requested Effective of Coverage/Change:			

DEPENDENT INFORMATION:

	<u>Name (last, first, middle)</u>	<u>Birth Date</u>	<u>Sex</u>	<u>Social Security #</u>
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, of 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 am either currently covered under a Major Medical/Comprehensive coverage with this Employer or have enrolled for Major Medical/Comprehensive coverage with this Employer; that the coverage for which I am applying may contain Pre-Existing Limitations; that the Master Policy for this coverage is issued to my Employer; and that I will receive a certificate as evidence of my insurance coverage under the policy.

Applicant's Signature _____ Date _____
 Parent or Legal Guardian if the Applicant is under age 18

Agent's Signature (where applicable by law) _____