

**POLICYHOLDER'S APPLICATION FOR OUTPATIENT PRESCRIPTION DRUG INSURANCE**

Please return to the Program Manager:  
Capital Insurance Managers, Inc.  
Texas Capital Insurance Managers, Inc.  
3534 Bee Caves Road, Suite 214  
Austin, TX 78746  
Phone: (800) 233-6145

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO

**I. APPLICANT INFORMATION**

Policy No. PD-110

Employer Name \_\_\_\_\_ Tax ID#: \_\_\_\_\_

DBA Name (if other than above): \_\_\_\_\_

Business Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Mailing Address (if other than above): \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Correspondent: \_\_\_\_\_ Title \_\_\_\_\_

Phone No: (\_\_\_\_) \_\_\_\_\_ Fax No: (\_\_\_\_) \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Type of Business:  Proprietorship  Corporation  Partnership  Other (Specify) \_\_\_\_\_  
If any subsidiary or affiliated companies are to be insured or any employees are working at a location other than the address above, please explain \_\_\_\_\_

Do you currently provide coverage under a medical benefit plan for all full time employees, unless waived? (If no, coverage cannot be issued.)  Yes  No

Current Medical Benefit Plan Insurer: \_\_\_\_\_ Policy No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Number of full time employees: \_\_\_\_\_ Minimum hourly requirement per week: \_\_\_\_\_

Number of persons on COBRA or FMLA continuation: Employees \_\_\_\_\_ Dependents \_\_\_\_\_  
(Please list names, qualifying event and date)

Do you wish to cover retired employees under this plan?  Yes  No If yes, number of retirees: \_\_\_\_\_

Are these retired employees covered under your current medical benefit plan?  Yes  No  
(If no, coverage cannot be issued to retirees.)

**II. PLAN SELECTION AND EFFECTIVE DATE**

Generic  Yes  No Preferred Formulary  Yes  No

Brand Name  Yes  No Open Formulary  Yes  No

Mail Service  Yes  No Oral Contraceptives, Contraceptive Devices  Yes  No

**Annual Deductible:** \_\_\_\_\_

Retail Pharmacy Copayments Per Prescription: \$ \_\_\_\_\_

Mail Order Pharmacy Copayments Per Prescription: \$ \_\_\_\_\_

New Employee Waiting Period \_\_\_\_\_ days Open Enrollment Period from \_\_\_\_\_ to \_\_\_\_\_

Benefit Period: \_\_\_\_\_

Maximum Benefit per Benefit Period: **\$100,000 per individual but not to exceed \$200,000 per family**

Requested Effective Date: 12:01 a.m. on the **1st** day of \_\_\_\_\_ 2009  
Month Year

**III. ELIGIBLE CLASS SELECTION**

Any person meeting the definition of an elected Class must also be covered under the applicant's current medical benefit plan in order to be eligible for coverage. Dependent children must be under age 19 (24 if a full time student). Evidence of insurability may be required for groups of 5-15 lives.

Coverage is requested for the following Classes:

- Employees  All actively at work, full time employees
- Dependents of Employees  Eligible employees' lawful spouses and unmarried dependent children
- Retired Employees  All retired employees of the applicant
- Dependents of Retired Employees  Eligible retirees' lawful spouses and unmarried dependent children
- Other \_\_\_\_\_

**IV. PREMIUMS**

\$ \_\_\_\_\_ per month, per certificate covering employee only  
\$ \_\_\_\_\_ per month, per certificate covering employee and one child  
\$ \_\_\_\_\_ per month, per certificate covering employee and children  
\$ \_\_\_\_\_ per month, per certificate covering employee and spouse only  
\$ \_\_\_\_\_ per month, per certificate covering employee and family

Employees:  premium is non-contributory - 100% of eligible employees must be covered.  
 premium is contributory. Percentage paid by employer: \_\_\_\_\_%

Dependents:  premium is non-contributory - 100% of eligible dependents must be covered.  
 premium is contributory. Percentage paid by employer: \_\_\_\_\_%

Premium + Monthly Service Charge submitted with application: \$ \_\_\_\_\_ + **\$20.00** = \$ \_\_\_\_\_

**Make check payable to: Fidelity Security Life Insurance Company**

**V. SIGNATURE**

We hereby make application to Fidelity Security Life Insurance Company for group insurance providing outpatient prescription drug benefits. We understand, and our agent has explained to us the policy benefits, limitations and exclusions.

We agree to 1) maintain and furnish any records necessary to administer the plan; 2) pay the required premiums monthly, prior to each premium due date; and 3) make available to eligible employees the ability to pay any required contributory premium through payroll deduction.

We understand that: 1) Fidelity Security Life Insurance Company intends to rely on this information in determining whether or not the enrolling employees and their dependents may become insured; 2) no insurance will become effective until approved by the Company; 3) no representative of the Company has the authority to modify any conditions of application or policies by making any promise or representation; 4) the insurance as to any person will not become effective on the date insurance should otherwise become effective until such time that he is at work on such date performing all duties of his occupation or carrying on a substantial part of the standard and commonly practiced activities of a person in good health of the same age and sex and otherwise meets the requirements of the Company.

The undersigned hereby certifies that 1) all persons for whom coverage is requested are covered under the applicant's medical benefit plan; 2) all of the information shown on this application and any attachments is correct and complete; and 3) the applicant has reviewed each employee enrollment form and verified that when dependent coverage has been elected, all eligible dependents are named.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_

Printed or Typed Name of Officer, Owner or Partner \_\_\_\_\_

Signature of Officer, Owner or Partner \_\_\_\_\_

Title \_\_\_\_\_

**WRITING AGENT'S CERTIFYING STATEMENT**

I certify that I have accurately recorded on this application the information supplied by the proposed Policyholder.

Agent Name (print): \_\_\_\_\_ Agent No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Agent Signature \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_