**Employer Name:** ____________________________________ Proposal/Quote Number: ______________________________

**Medical Indemnity Coverage Application**

Date Quoted: ______________________________

| | |
|---|---|
| Plan Selected: | ☐ WIBA PLAN A ☐ WIBA PLAN B ☐ WIBA PLAN C ☐ WIBA PLAN D<br>Policy Number: LM-100 |

Legal Name of Employer (include d/b/a):

| | | | | |
|---|---|---|---|---|
| Business Address: | (Street) | (City) | (State) | (Zip Code) |
| Mailing Address:<br>(if other than above): | (Street) | (City) | (State) | (Zip Code) |

| | |
|---|---|
| Contact Person & Title: | Email: |
| Telephone Number: | Fax Number: |

| | | | |
|---|---|---|---|
| ☐ Corporation | ☐ Partnership | ☐ Sole Proprietorship | ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| Eligible Class of Employees (check all that apply): | ☐ Management Only | ☐ Salaried | ☐ Hourly | ☐ All Full-time |

If any subsidiary, affiliated company or division is to be insured or any employees are working at a location other than the address above, please explain:

| | |
|---|---|
| SIC Code: | Nature of Business: |
| FEIN Number: | Years in Business (under Legal Name): |

| | |
|---|---|
| Do your Employees, or any classification of Employees, have Group Coverage under another carrier? | ☐ Yes ☐ No |

If "Yes", will this insurance replace it? ☐ Yes ☐ No

Current Insurer's Name and Telephone Number:

(enclose copy of current carrier billing and policy #)

Classes of Employees eligible for Coverage: All: Other:

| | |
|---|---|
| Minimum Hourly Requirement per Week: 15 hours | Number of Employees Working the Required Minimum Hours: |
| Number of Employees Electing Coverage: | Number of Employees Waiving Coverage: |

Number of Employees and Dependents currently totally disabled:

Number of Persons on COBRA or State Continuation: Employees: Dependents:

| | |
|---|---|
| Provide Names, Qualifying Events and Start Dates: | |

PLAN SELECTION AND EFFECTIVE DATE.

| | |
|---|---|
| ☒ RX : Employee ☒ Dependents ☒ | |
| | |

| | | | | |
|---|---|---|---|---|
| ☒ Supplemental Term Life Insurance:<br>(Includes Accidental Death and Dismemberment for Employee Only) | Option 1 ☐ | $10,000 Employee<br>$ 5,000 Spouse<br>$ 2,500 Child(ren) | Option 1 ☒ | $ 5,000 Employee |

**Complete Reverse Side**

**FIDELITY SECURITY LIFE INSURANCE COMPANY**

Kansas City, Missouri 64111

| Maternity Coverage: ☒ Yes ☐ No | | | |
|---|---|---|---|
| Employer Contribution: | Medical Indemnity: | Employee % | Dependent % |
| | | | |
| | | | |
| Waiting Period for New/Existing Employees (check one): ☐ None ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other | | | |
| | Waive Waiting Period for Current Employees: ☐ Yes ☐ No | | |
| Open Enrollment Period from | | to | |
| Requested Effective Date: 12:01 A.M. on the 1st day of | | 20 | |
| **Do not terminate existing coverage until you have received confirmation of coverage from the Company!** | | | |

**Agreement Section**

We understand, and our agent has explained, the limitations and exclusions, including the pre-existing condition limitations.

We agree to contribute a minimum of ________% toward the Employee's premium and ________% toward the Dependent premium.

All statements made herein are complete and true and I understand that Fidelity Security Life Insurance Company (FSL) will rely on these statements and this information as the basis for approving this application.

It is further understood that no insurance will become effective without the approval of FSL. Do not cancel other coverage (if any) until notified by FSL of acceptance of this application. It is agreed that coverage for an Employee not actively at work at his or her usual place of employment on the day his or her insurance would otherwise become effective, will not become effective until the day following the date he/she returns to active employment. Insurance for any eligible person will not become effective if such person is hospital confined or unable to perform his/her Regular and Customary Activities. Such person's insurance will not become effective until the 1st of the month following the date of hospital discharge and on which he/she engages in his/her Regular and Customary Activities. No person's insurance will become effective before the Employee's insurance is effective.

We agree to make any necessary payroll deductions for any Employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. We request that the Administrator bill our share of the premiums due under any insurance policy issued.

We understand that the Policyholder may terminate the Policy by providing written notice to the Company at least 31 days prior to termination. The Company may terminate the Policy on the first day of any month on or after the first Policy Anniversary Date by providing written notice to the Policyholder at least 31 days prior to termination. The Policyholder is responsible for notifying the Insured of the termination or non-renewal of the Policy.

We understand that the Company and the Policyholder may agree to amend the Policy at any time without the consent of any Employee or other person.

We hereby represent that the information herein is true and complete and that I have read and understand this form.

We understand that existing coverage should not be canceled until notified in writing that this Application is accepted by FSL.

The undersigned acknowledges and understands that any misrepresentation on this Application by him or her or any of their agents or Employees may result in the cancellation or rescission of any Policy issued based on this Application.

**I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this application for the Policyholder's state of domicile.**

Make check payable to Fidelity Security Life Insurance Company

| | |
|---|---|
| ______________________________ | ______________________________ |
| Printed or Typed Name of Officer, Owner, or Partner | Title |
| ______________________________ | ______________________________ |
| Signature of Officer, Owner, or Partner | Date |

## PRODUCER'S INFORMATION

| **Writing Producer: WIBA Insurance Services, Inc.** | | |
|---|---|---|
| Producer Agent Number: | | |
| Name: Karen Fillenworth | Address: | |
| Tax ID Number: | Social Security Number: | Phone Number: ( 316 ) 267-8987 |
| • Do you have a broker license?: ☐ Yes ☐ No | Commission Paid to: **WIBA Insurance Services, Inc.** | |
| Licensed with Fidelity Security Life Insurance Company in the state where this Employer is located on | | |
| (date | | |
| • If "Yes", please submit copy | | |

| **General Agent** | | |
|---|---|---|
| General Agent Number: | | |
| Name: | Address: | |
| Tax ID Number: | Social Security Number: | Phone Number: ( ) |
| • Do you have a broker license?: ☐ Yes ☐ No | Commission Paid to: | |
| Licensed with Fidelity Security Life Insurance Company in the state where this Employer is located on | | |
| (date) | | |
| • If "Yes", please submit copy | | |

### PRODUCER'S STATEMENT

All statements in the Group Application are true and complete. I understand that I represent the interest of the Applicant firm for insurance, not the Insurance Company, nor the Administrator. I have advised the Applicant firm not to cancel any existing coverage unless and until notified in writing. I understand that I have no right to bind this coverage or alter the terms of the Policy in any matter. All Policy limitations and exclusions, including pre-existing condition limitations, have been explained to the Applicant firm.

| | | Karen Fillenworth |
|---|---|---|
| Producer's Signature | Date | Print Producer's Name |

| FRAUD WARNING NOTICE | |
|---|---|
| **For residents of all states** (except the following)} | Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. |
| **Arkansas** | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **Colorado** | It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. |
| **District of Columbia** | Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant. |
| **Florida** | Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree. |
| **Kentucky** | Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. |
| **Louisiana** | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **Maine** | It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. |
| **Nebraska** | Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. |
| **New Jersey** | Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. |
| **New Mexico** | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. |
| **Pennsylvania** | Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. |
| **Tennessee** | It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. |