# Alabama State Employees Association
# Group Term Life Insurance Application

**Underwritten by Fidelity Security Life Insurance Company**

Policy No. TL-44

## 1 Applicant Information: (Please type or print in ink.)

First Name: ____________ Middle: ____________ Last: ____________

Address: ____________ (Street, Apt. No.) E-mail Address: ____________

City: ____________ State: ________ ZIP: ________

Sex: M F Current Age: ______ Date of Birth: ________ Height: ________ Weight: ________

Social Security No: ____________ State of Birth ________ Home Phone: (____) ____________

Occupation: ____________ Daytime Phone: (____) ____________

Beneficiary: ____________ (First Middle Last) Relationship: ____________

## 2 Guaranteed Issue (Member only):

I wish to apply for $100,000 $125,000 $150,000 $200,000 $250,000

Have you, or any proposed insured, used any tobacco products during the past 12 months? ........................ Yes No

If yes, which person(s)? ____________

## 3 Please Complete for Spouse Coverage:

Spouse's First Name: ____________ Middle: ____________ Last: ____________

Sex: M F Current Age: ______ Date of Birth: ________ Height: ________ Weight: ________

Social Security No.: ____________ Occupation: ____________ State of Birth: ____________

You will be the beneficiary of your spouse's coverage unless you request otherwise.

## 4 Please Complete for Dependent Child(ren) Coverage:

| First, Last Name | Relationship | Date of Birth | Age | Height | Weight |
|---|---|---|---|---|---|
| | | | | | |
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You will be the beneficiary of your child(ren)'s coverage unless you request otherwise.

## 5 Please Answer All Questions for You, Your Spouse and Your Dependent Child(ren):

1. Have you, or any proposed insured, ever been diagnosed or treated by a physician/medical professional for: heart or circulatory disorder, high blood pressure, nervous system or seizure disorder, nervous or mental disorder, kidney or liver disorder, respiratory or lung disorder, digestive system disorder, musculo-skeletal disorder, cancer or tumor, stroke, paralysis, diabetes, hemophilia or leukemia, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immune system disorder?.................................................. Yes No
2. Are you, or any proposed insured, now taking medication or receiving medical attention?.................. Yes No
3. In the past 24 months, have you, or any proposed insured, had: swollen glands, recurrent diarrhea, fever or infection, persistent cough, pneumonia or thrush?.................................................. Yes No
4. In the past 5 years have you, or any proposed insured, been treated or confined to any hospital, medical or psychiatric facility or been seen by a physician/medical professional for any reason other than stated above? .................................................. Yes No

**Be sure to complete and sign reverse side**

5. Are you, or any proposed insured, now disabled or eligible for any disability benefits, Workers' Compensation benefits or waiver of premium for life or health insurance? ............................................ Yes No

6. In the past 12 months, have you, or any proposed insured, engaged in any scuba diving, sky diving, auto or boat racing, hang gliding or other hazardous activity? ................................................................ Yes No

7. In the past 5 years have you, or any proposed insured, been convicted of or pled guilty to driving while under the influence of alcohol and/or drugs? ................................................................................. Yes No

If any answer is "Yes," give details below. (If additional space is needed, fill out separate sheet in ink. Sign, date and attach to this form.)

| Question Number | Person | Condition | Dates | Treatment | Names & Addresses of Physicians, Hospitals, Clinics | Patient I.D. |
|---|---|---|---|---|---|---|
| | | | | | | |
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## 6 Authorization:

I understand that the insurance applied for becomes effective on the date specified by the Fidelity Security Life Insurance Company ("the Company") only if this application is accepted by the Company and the first premium is paid during my lifetime. I represent that as of the date I signed this application, all statements and answers recorded on this application are true and complete and are made to obtain the insurance applied for. These statements are to be considered representations and not warranties. I understand that any false statement or material misrepresentation in the application may result in claim denial or rescission of coverage, and that if coverage is rescinded the Company's only obligation will be to refund all premiums paid.

I have received and read a copy of the Pre-Notice which describes how information is obtained and used by the Company. I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance company, its authorized representatives, Pharmacy Benefit Manager, MIB, Inc. (MIB), IntelliScript, or other organization or institution that has any records or knowledge of me or my physical or mental health, including significant history, findings, diagnoses and treatment or nonmedical information, such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications of insurance, to give to the Company, its plan administrators, business associates, or its reinsurers, any such information for use to: 1) underwrite my applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company. The Company or its authorized representatives may release to its plan administrators, business associates, other insurance companies, MIB, or others whom I authorize in writing, information covered by this authorization. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date shown below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Fidelity Security Life Insurance Company at P.O. Box 418131, Kansas City, MO 64141-8131, Attention: Privacy Officer. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I will receive a copy of this authorization.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

## 7 Signature and Payroll Deduction Authorization:

I understand that, hereafter, the regular monthly premiums will be deducted from my paycheck.

Member's Signature **X** ______________________________ Date ____/____/_____

Date Employed ____/____/_____ Department/Agency __________________ Division ______________________

Home Phone No. (________)________________________ Work Phone No. (________) ______________________

Signature of Spouse (if applying) **X** ______________________________ Date ____/____/_____

Signature of Child (if over 18) **X** ______________________________ Date ____/____/_____

**Presented by:**

**Countryman & Smitherman, Inc.**
Prattville, AL 36066

**Mail this application in the postage-paid envelope provided to:**
ASEA Benefits Office, 110 N. Jackson Street, Montgomery, AL 36104

**Any Questions? Call Countryman & Smitherman at (877) 777-4301**

**Underwritten and administered by:**

**Fidelity Security Life Insurance Company**
Kansas City, MO 64111

188-32495 #6202 0113