Policy No. MG-108; M-9054E

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

FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE

MAJOR MEDICAL COMPLEMENT

Arranged by:
Allstate Workplace Division
Group New Business
1776 American Heritage Life Drive, 3rd Floor
Jacksonville, FL 32224
Fax: 1-972-510-1786

PLAN INFORMATION:

As selected by the Policyholder

In Hospital Benefit Amounts

☐ Plan I:	$ _____	In-Hospital Benefit
	$ _____	Optional Out-Patient Benefit (R-02822)
	$ _____	Optional Physician Benefit Rider
	$ _____	Optional Wellness Rider
☐ Plan II:	$ _____	In-Hospital Benefit
	$ _____	Optional Out-Patient Benefit (R-02822)
	$ _____	Optional Physician Benefit Rider
	$ _____	Optional Wellness Rider

APPLICANT INFORMATION:

Name (last, first, middle)				Sex ☐ M ☐ 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:	☐ Employee Only ☐ Employee & Child(ren)		☐ Employee & Spouse ☐ Employee & Family	
Monthly Premium:		Requested Effective of Coverage/Change:		

DEPENDENT INFORMATION:

	Name (last, first, middle)	Birth Date	Sex	Social Security #
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, if 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.

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.

Applicant's Signature _____ Date _____

Parent or Legal Guardian if the Applicant is under age 18

Agent's Signature (where applicable by law) _____

Agent's License Number: _____