

**FOR HOSPITAL CONFINEMENT
INDEMNITY COVERAGE
MediBridge**

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

MAIL TO:
Comprehensive Insurance Agency, LLC
3601 Algonquin Rd – Suite 850
Rolling Meadows, IL 60008

Policy No.
BB-17A,
BB-17D

PLAN INFORMATION:

IN-HOSPITAL BENEFIT AMOUNTS:

- | | | | |
|----------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> \$500 | <input type="checkbox"/> \$1,500 | <input type="checkbox"/> \$3,000 | <input type="checkbox"/> \$6,000 |
| <input type="checkbox"/> \$750 | <input type="checkbox"/> \$1,750 | <input type="checkbox"/> \$3,500 | <input type="checkbox"/> \$7,000 |
| <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$4,000 | <input type="checkbox"/> \$8,000 |
| <input type="checkbox"/> \$1,250 | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 |
- Optional Wellness Benefit Rider** - \$100 \$200 \$500
- Optional Outpatient Benefit I** - \$200 \$500
 \$750 \$1000
- Optional Outpatient Benefit II (Individual/Family)**
- | | | |
|--|--|--|
| <input type="checkbox"/> \$500/\$1000 | <input type="checkbox"/> \$750/\$1500 | <input type="checkbox"/> \$1000/\$2000 |
| <input type="checkbox"/> \$1250/\$2500 | <input type="checkbox"/> \$1500/\$3000 | <input type="checkbox"/> \$1750/\$3500 |
| <input type="checkbox"/> \$2000/\$4000 | <input type="checkbox"/> \$2250/\$4500 | <input type="checkbox"/> \$2500/\$5000 |

APPLICANT INFORMATION: Please type or print in ink:

Collected Premium \$ _____

Name (last, first, middle) _____		Sex _____	Birth Date _____
Age _____	Social Security No. _____	Occupation _____	() _____
Street Address _____	City _____	State _____	ZIP _____ Telephone No. _____

DEPENDENT INFORMATION:

Name (last, first, middle) _____	Sex _____	Soc. Sec. No. _____	Occupation _____	Birth Date _____
Spouse _____	_____	_____	_____	_____
Child _____	_____	_____	_____	_____
Child _____	_____	_____	_____	_____
Child _____	_____	_____	_____	_____

PAYMENT INFORMATION: First Modal Premium is due at time of application.

Billing Form/Mode **ADD \$10.00 TO INITIAL PREMIUM FOR INDIVIDUAL APPLICATIONS** ____/01/200__

INDIVIDUAL COVERAGE	GROUP COVERAGE	Requested Effective Date _____
<u>Monthly</u>		NO BACKDATING ALLOWED
____ Credit Card (complete A on reverse side)	____ Payroll Deduction (If Employer allows)	
____ Electronic Transfer (complete B on reverse side)	____ (complete C on reverse side)	<u>Make Check Payable to:</u> <u>Fidelity Security Life Insurance</u>

No Monthly Individual Direct Bill **Direct Bill** (complete D on reverse side): Quarterly Semi-Annually Annually

I UNDERSTAND AND ACKNOWLEDGE:

- That to be eligible for this plan, I, and any of my dependents to be insured, must have Major Medical/Comprehensive coverage with a coinsurance and deductible amount in force as of my proposed Effective Date for this coverage. I, and any of my dependents to be insured are either currently covered under a Major Medical/Comprehensive coverage or have enrolled for Major Medical/Comprehensive Coverage with this Employer. The benefit amount selected should be sufficient to cover my current coinsurance and deductible needs.
- That benefits payable under any other group hospital indemnity coverage may reduce the benefits payable under this coverage. Benefits payable under this coverage will be reduced so that the total benefit payable under the coverage and any other coverage does not exceed the total charges incurred or the maximum benefit payable under this coverage. Benefits will not be reduced if total benefits under all coverage is less than \$100.
- That by applying for this insurance coverage I am: (a) enrolling as a member of the United Associations of America Group Insurance Trust or (b) certifying that I am an employee or member of an organization participating in the Trust.
- That the master policy for this insurance coverage is issued to the United Associations of America Group Insurance Trust. I will receive a certificate as evidence of my insurance coverage under the trust policy.

Date _____ Signature of Applicant _____
Parent or Legal Guardian if the Applicant is Under Age 18

Note: Please complete all information requested. Coverage cannot be effective earlier than the first of the month following receipt and approval of your application by the Company and upon payment of your first full premium amount.

