

Employer Application MediBridge

Ship To:
Comprehensive Insurance Agency, LLC
3601 Algonquin Rd, Rolling Meadows, IL 60008

Application is hereby made by

(full name of organization/firm)

Type of Business _____

Located at _____

Number

Street

City _____

State _____

Zip _____

E-Mail Address _____

Underwritten by Fidelity Security Life Insurance Company - 3130 Broadway, Kansas City, MO 64111-2406

1 Insurance shall be:
 Non-Contributory (Employer assumes entire cost of plan)
Percentage of Employee Contribution: _____ %

Contributory
Occupation: _____

2 Total number of employees: _____
Number of employees eligible for this plan: _____
Number of employees participating: _____
Percentage of participating employees: _____ %
Number of dependents to be covered: _____

Eligible employees (including owners, partners, and executive officers) are defined as those who are engaged in their regular and customary activities (at least 20 hours per week), and not confined at home or in a hospital or medical institution

As selected by the Policyholder

3 In-Hospital benefits requested for all employees: <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,250 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$7,000 <input type="checkbox"/> \$8,000 <input type="checkbox"/> \$10,000	Optional Outpatient Benefit Rider I: <input type="checkbox"/> \$200 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000
	Optional Wellness Benefit Rider: <input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$500
Optional Outpatient Benefit Rider 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	

4 Billing Method: Monthly List Bill (minimum 5 employees)
 Monthly Electronic Funds Transfer (minimum 5 employees)
Direct Bill: QT (minimum 5 employees) SA (minimum 5 employees) AN (minimum 5 employees)
First Modal Premium is due at time of application, All Groups, All Modes

Billing Information: _____

Mailing/Billing Address: _____

Are multiple billings required? Yes No If Yes, attach a list of each location and their physical address. (NOTE: Agent must be licensed and appointed in each state.)

Copy Agent in on all correspondence? Yes No If No, all correspondence will be handled directly with the Employer.
The effective date of this insurance applied for will be the first day of the month following the acceptance of employee Enrollment Forms by the Company and receipt of premium payment.

Requested effective date for group: _____ /01/200_____ First of the month ONLY

New employees are eligible the first of the month following employment.

I understand that requests submitted to the Company for individual employee cancellation of coverage and return of premium, if any, must be signed by the employee.

Signature of Employer _____ Title _____ Date _____

Contact Person _____ Daytime Telephone No. _____
(please print)

ELECTRONIC FUNDS TRANSFER:

I wish to have my monthly premium deducted from the checking account number shown on the attached check (PLEASE SEND VOIDED CHECK). I authorize my bank to withdraw the appropriate premium on a monthly basis. I understand that, if I wish to discontinue this authorization or my checking account number changes, I will notify in writing Fidelity Security Life Insurance Company.

Signature of Depositor _____
(as it appears on checking account)

AGENT INFORMATION:

Writing Agent Name _____

Agent Address _____

E-Mail Address _____

Tax ID No. (If none, Social Security No.) _____

Commission Paid To _____ Are you appointed with Fidelity Security Life Insurance Company? Yes No
If "No", contact Fidelity Security Life Insurance Company immediately regarding appointment.

The standard Pre-Existing Condition definition reads as follows:

An Injury or Sickness which has been diagnosed by a legally qualified Physician, with consultation, advice or treatment occurring within 12 months prior to an Insured Person's Effective Date of coverage. Pre-Existing Condition also means symptoms of a condition that would have led an ordinarily prudent person to seek diagnosis, care or treatment. Such an Injury or Sickness will continue to be a Pre-Existing Condition until the earlier:

- a.** the expiration of 12 consecutive months beginning with the Effective Date of coverage, for which the Insured Person has not received any medical care, consultation, diagnosis or treatment, or has not taken any prescribed drug or medicine on account of such condition; or
- b.** the expiration of 24 consecutive months, beginning with the Effective Date of coverage.

However, if a group has 75% participation of all eligible employees, and those eligible for coverage do not engage in the occupations listed below, the following modifications will apply:

75% of 25 or more eligible lives: Pre-Existing Condition limitation will be WAIVED.

The following occupations are only eligible for the standard pre-existing condition limitation, regardless of the number of lives covered:

- | | |
|---|---------------------------------|
| Attorneys | Roofers |
| Amusement Park Workers | Industrial Saw Sharpeners |
| Bail Bondsmen | Martial Arts Schools |
| Bar, Tavern and Lounge Workers | Loggers and Sawmill Workers |
| Barbers | Massage Parlors |
| Beauticians | Oil Well Drilling & Exploration |
| Blasters | Parking Lot Attendants |
| Car Wash Employees | Pawn Brokers |
| Carnival or Circus Workers | Physicians (i.e. M.D. or D.O.) |
| Cosmetologists | Police Officers |
| Crop Dusters | Psychiatrists |
| Dock Workers | Psychologists |
| Entertainers and other performers, | Race Car Drivers |
| theatrical road crews & support personnel | Race Track Employees |
| Explosive Handlers and Manufacturers | Rodeo Performers |
| Fire Fighters | Sanitary Workers |
| Foundry Workers | Security Guards |
| Gambling Casino Employees | Steeplejacks |
| Hairdressers | Structural Steel Workers |

The following occupations are not eligible for coverage under The MediBridge plan:

- | | |
|-----------------------|----------------|
| Professional Athletes | Ironworkers |
| Mining and Quarrying | Window Washers |
| Deep Sea Divers | |

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-25A,
BB-25D

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)
 \$500/\$1000 \$750/\$1500 \$1000/\$2000
 \$1250/\$2500 \$1500/\$3000 \$1750/\$3500
 \$2000/\$4000 \$2250/\$4500 \$2500/\$5000

APPLICANT INFORMATION:

Name (last, first, middle)					Sex <input type="checkbox"/> M <input type="checkbox"/> 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:		<input type="checkbox"/> Employee		<input type="checkbox"/> Employee & Spouse		
		<input type="checkbox"/> Employee & Child		<input type="checkbox"/> Employee & Family		
Monthly Premium: \$		Requested Effective Date of Coverage/Change:				

DEPENDENT INFORMATION

	Name (last, first, middle)	Birth Date	Sex	Social Security #
Spouse				
Child				
Child				
Child				

(Use additional sheet if additional space is needed)

I hereby: **ENROLL** as indicated above, for this group insurance coverage for which I am eligible, or **CHANGE** information submitted on my original application. 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 and any of my dependents to be insured, are 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. I will receive a certificate as evidence of my insurance coverage under the policy.

Applicant's Signature _____
Parent or Legal Guardian if the Applicant is Under Age 18

Date _____

Agent's Signature _____ (where applicable by law)

APPLICANT AUTHORIZATION

PAYROLL DEDUCTION:

To:

Employer

I hereby authorize you to deduct from my salary or wages the amount necessary to pay the required premium 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.

Payroll No.: _____

Employee Signature: _____ Date: _____

AGENT INFORMATION:

Writing Agent Name: _____ Agent Code #: _____

Agent Address: _____

Tax ID No. (If none, Social Security No.): _____

Commission Paid To: _____ Are you licensed with Fidelity Security Life Insurance Company? Yes No