# INFORMATION SHEET

Legal Name of Group: _____
As it should appear on the Policy — List subsidiaries/affiliates to be covered on back

Address: _____

Phone #: _____ Federal Tax I.D. #: _____ SIC #: _____

Fax #: _____ Nature of Business: _____

Contact Name: _____

Are you required to file with the Railroad Commission: ❑ Yes ❑ No *(If "Yes", contact your Agent for special requirements.)*

Are Owners to be covered? ❑ Yes ❑ No Are Owners on the State Employment Commission Report? ❑ Yes ❑ No

Please print the names of all Owners: _____

Requested Effective Date: _____

Deductible Requested: ❑ $500 ❑ $1,000 ❑ $5,000 ❑ $10,000 ❑ $25,000 ❑ Other: _____

Benefit Period: ❑ 52 Weeks ❑ 104 Weeks ❑ 156 Weeks

Coverage Selected: ❑ Occupational Only ❑ 24-Hour Business & Pleasure

Choose One: ❑ Loss of Use or ❑ Permanent & Total Disability (Lump Sum)

Is Policy to cover: ❑ Employees Only or ❑ Employees and Contract Labor

| Classes | DEFINITION | CARE BENEFIT | # OF LIVES* | | MONTHLY FACTOR | | MONTHLY PREMIUM |
|---|---|---|---|---|---|---|---|
| Class A | | | | x | | = | |
| Class B | | | | x | | = | |
| Class C | | | | x | | = | |
| Class D | | | | x | | = | |
| Class E | | | | x | | = | |
| Class F | | | | x | | = | |

Total Monthly Premium for All Classes: $ _____
(Minimum $50)

Monthly Administration Fee: $ 25.00

Total Monthly Cost: $ _____
(Payable to Fidelity Security Life Insurance Company)

*The # of lives used should be the actual employee head count as of the requested effective date of coverage.

Agent Name: _____

Phone #: _____ Fax #: _____ Agent #: _____

This form does not bind any agent or insurance company to coverage. This is a Quotation/Policy request form and will not effect any insurance until approved by the Company or its representatives. The information above is true and acceptable to the best of my knowledge.

_____ _____ _____
Applicant's Signature (Officer) Title Date

_____
Print/Type Name Above