

# Employer Application

## SISLink™

Special Insurance Services, Inc.

6509 Windcrest Drive, Suite 200

Plano, Texas 75024

(972) 788-0699 (800) 767-6811

Fax: (972) 960-0377

Policy No. BB-13; M-9051TX

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

### 1 Insurance shall be:

Non-Contributory (Employer assumes entire cost of plan)

Contributory

Percentage of Employee Contribution: \_\_\_\_\_%

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*

### 3 In-Hospital Plan of benefits requested for all employees: Plan I: \$\_\_\_\_\_ Plan II: \$\_\_\_\_\_

\$500

\$1,000

\$1,250

\$1,500

\$1,750

\$2,000

\$2,500

\$3,500

\$5,000

Other \_\_\_\_\_

Outpatient Benefit Plan I: \$\_\_\_\_\_ Plan II: \$\_\_\_\_\_

\$200

\$500

\$750

\$1,000

Other \_\_\_\_\_

Physician Benefit Plan I: \$\_\_\_\_\_ Plan II: \$\_\_\_\_\_

\$15 visit up to the lesser of \$120 or 8 visits per family, per Calendar Year

\$20 visit up to the lesser of \$240 or 12 visits per family, per Calendar Year

Wellness Rider Plan I: \$\_\_\_\_\_ Plan II: \$\_\_\_\_\_

\$100

\$200

\$500

### 4 Billing Method: Monthly List Bill (minimum 3 employees/members)

Direct Bill:  Quarterly  Semi-annual  Annual (1-2 employees)

(First Modal Premium is due at time of application.)

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.)

Mail Premium Notice to:  Employer  Third Party Payor\*

\* Third Party Payors must be pre-approved by Home Office. A letter from the employer must be submitted with the business requesting that their billings be sent to the Third Party Payor. The Third Party Payor must also sign a Privacy Non-Disclosure Agreement.

Third Party Payor:

Mailing Address: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

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 later of the first day of the month following the acceptance of employee Enrollment Forms by the Company and receipt of premium payment, or the Employee's effective date under the Employer's Major Medical/ Comprehensive coverage.

Requested effective date for group: \_\_\_\_\_

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. \_\_\_\_\_

**EMPLOYER AUTHORIZATION**

**DIRECT BILL:**

Organization/Firm \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
(If different from the first page)

Employer's Signature \_\_\_\_\_

**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.



Pre-Existing Condition means an Injury or Sickness, which has been diagnosed by a legally qualified Physician, with consultation, advice or treatment occurring within 12 months immediately 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 and not be covered until the expiration of 12 consecutive months, beginning with the Effective Date of coverage.

Certain groups may be eligible for a Pre-Existing Condition Waiver, based on size and/or employer contribution levels.

The following occupations are not eligible for coverage:

- |  |                                 |
|--|---------------------------------|
| Attorneys  | Ironworkers                     |
| Amusement Park Workers   | Loggers and Sawmill Workers     |
| Bail Bondsmen  | Martial Arts Schools            |
| Bar, Tavern and Lounge Workers   | Massage Parlors                 |
| Barbers  | Mining and Quarrying            |
| 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   | Professional Athletes           |
| Deep Sea Divers  | Psychiatrists                   |
| Dock Workers   | Psychologists                   |
| Entertainers and other performers, theatrical road crews & support personnel | Race Car Drivers                |
| Explosive Handlers and Manufacturers   | Race Track Employees            |
| Fire Fighters  | Rodeo Performers                |
| Foundry Workers  | Roofers                         |
| Gambling Casino Employees  | Sanitary Workers                |
| Hairdressers   | Security Guards                 |
| Industrial Saw Sharpeners  | Steeplejacks                    |
| Interstate Truck Drivers   | Structural Steel Workers        |
|  | Window Washers                  |

Initials: \_\_\_\_\_ Date: \_\_\_\_\_