



ALABAMA STATE EMPLOYEES ASSOCIATION
Application For Group Whole Life Insurance
“Senior Whole Life”

Policy No. SW-5
188-6300

I APPLICANT INFORMATION:

Last Name: _____ First: _____ Middle: _____

Address: _____

City: _____ State: _____ ZIP: _____
(Street, Apt. no.)

Sex: Male Female Age: _____ Date of Birth: _____
Month Day Year

Classification: _____ Social Security No.: _____

Daytime Phone: (____) _____ Home Phone: (____) _____

Person to be paid:

Beneficiary: _____ Relationship: _____
First Middle Last

II PLEASE CHOOSE YOUR COVERAGE OPTIONS:

\$2,000 \$5,000 \$10,000 \$20,000

III SIGNATURE:

I understand that if death occurs from natural causes within two years from the effective date of insurance, the benefit is limited to 125% of the annual premium in the first Certificate Year and 250% of the annual premium in the second Certificate Year. I understand that if death occurs from suicide within two years from the effective date of insurance, no death benefit is payable, and the Company's only obligation will be to refund all premiums paid for that person.

I understand and agree that the statements and answers in this application are complete and true as of the date I signed this application, and that this application becomes part of the contract of insurance. I understand that any false statement or material misrepresentation in the application may result in claim denial or rescission of coverage, and that if coverage is rescinded the Company's only obligation for that person will be to refund all premiums paid. I also understand and agree that the insurance, if issued, will take effect on the effective date stated in the Certificate Schedule provided this application has been accepted by the Company, the first premium has been received by the Company and paid in full, and that I am alive on the effective date.

Date: _____ Signature of Applicant: _____

A-00763

Policy Form #M-1007

Read the enclosed brochure, then decide how much coverage you need. **Do not send money now.**

Marketed by: Countryman & Smitherman, Inc. ● Prattville, Ala. 36066

Underwritten and Administered by: Fidelity Security Life Insurance Company ● Kansas City, Mo. 64111-2406

PAYROLL DEDUCTION AUTHORIZATION TO ASEA

I understand that, hereafter, the regular monthly payments will be deducted from my paycheck.

Signed _____ Date _____

Department/Agency _____ Social Security No. _____

Division _____ Home Phone No. (____) _____

Date Employed ____/____/____ Work Phone No. (____) _____

Mail this enrollment form in the postage-paid envelope provided to:
Alabama State Employees Association ● 110 N. Jackson Street ● Montgomery, AL 36104

Any questions? Call (334) 834-6965