ASEA Member Enrollment Form for the ASEA Term Life Insurance Plan

Underwritten by Fidelity Security Life Insurance Company

Policy No. TL-44
76745

1. Check One below to select Term Life Plan A, B, C, or D that you want:

- ☐ **Plan A $50,000**
- ☐ **Plan B $100,000**
- ☐ **Plan C $200,000**
- ☐ **Plan D $250,000**

2. All Applicants Complete (Please type or printin ink.)

	Social Security #:	E-mail Address:
Full Name: First Middle Last	Date of Birth (month/day/year):	Place of Birth (city, state):
Street Address:	Age:	☐ Male ☐ Female
City, State, ZIP:	Height: _______Ft. _______In.	Weight: ___________Lbs.
My beneficiary is to be: First Middle Last ☐ Male ☐ Female	Relationship to Me:	Beneficiary's Date of Birth:
Beneficiary's Address:		

3. All Applicants Complete:

	Yes	No
a. During the past 2 years, were you unable to perform your normal activities for more than 10 consecutive working days due to sickness or accident?	☐	☐
b. During the past 5 years, have you been diagnosed or treated by a physician (or been advised to seek treatment) for a heart disorder; high blood pressure; stomach, kidney or liver disorder; cancer or tumor; brain or nervous system disorder; paralysis or bone disorder; mental or nervous disorder; respiratory or lung disorder; diabetes; blood disorder; or Acquired Immunodeficiency Syndrome (AIDS),AIDS Related Complex (ARC) or any otherimmune disorder?	☐	☐
c. Have you been confined in a hospital or otherinstitution due to illness in the past6 months?	☐	☐

4. Please turn over. Sign and date where indicated. Your application cannot be processed without your signature. Complete Item #5 if applying for $100,000 or more.

A-00754 M-1004

ASEA Spouse Enrollment Form for the ASEA Term Life Insurance Plan

Underwritten by Fidelity Security Life Insurance Company

Policy No. TL-44
76745

1. Check One below to select Term Life Plan A, B, C, or D that you want:

- ☐ **Plan A $50,000**
- ☐ **Plan B $100,000**
- ☐ **Plan C $200,000**
- ☐ **Plan D $250,000**

2. All Applicants Complete (Please type or printin ink.)

	Social Security #:	E-mail Address:
Full Name: First Middle Last	Date of Birth (month/day/year):	Place of Birth (city, state):
Street Address:	Age:	☐ Male ☐ Female
City, State, ZIP:	Height: _______Ft. _______In.	Weight: ___________Lbs.
My beneficiary is to be: First Middle Last ☐ Male ☐ Female	Relationship to Me:	Beneficiary's Date of Birth:
Beneficiary's Address:		

3. All Applicants Complete:

	Yes	No
a. During the past 2 years, were you unable to perform your normal activities for more than 10 consecutive working days due to sickness or accident?	☐	☐
b. During the past 5 years, have you been diagnosed or treated by a physician (or been advised to seek treatment) for a heart disorder; high blood pressure; stomach, kidney or liver disorder; cancer or tumor; brain or nervous system disorder; paralysis or bone disorder; mental or nervous disorder; respiratory or lung disorder; diabetes; blood disorder; or Acquired Immunodeficiency Syndrome (AIDS),AIDS Related Complex (ARC) or any otherimmune disorder?	☐	☐
c. Have you been confined in a hospital or otherinstitution due to illness in the past6 months?	☐	☐

4. Please turn over. Sign and date where indicated. Your application cannot be processed without your signature. Complete Item #5 if applying for $100,000 or more.

A-00754 M-1004

i. Complete for $100,000 or larger plan:

	Yes	No
a. Have you used any tobacco products during the last 12 months?	☐	☐
b. Have you ever had life or health insurance declined,modified or rated up?	☐	☐
c. Are you now taking medication or receiving medical attention?	☐	☐
d. Have you been confined in the last 5 years to a hospital or othermedical facility or seen a doctor for any reason other than stated above?	☐	☐

If "yes" to any part of items 3 or 5, give details below. Use a separate sheet of paperifmore space is needed for answers.

Question No.	Person	Condition	Dates	Treatment	Name & Addresses of Doctors, Hospitals, Clinics

i. Please Sign and Date:

I understand the insurance applied for shall become effective on the date specified by the Company onlyif this application is accepted by the Company and firstpremium is paid during the lifetime of the insured. I represent that, as of the date I signed this application,all statements and answers recorded on this application are true and complete and are made to obtain the insurance applied for. I agree that this application shall become part of my certificate.

I have received and read a copyof the Pre-Notice, which describes how information is obtained and used by Fidelity Security Life Insurance Company. I hereby authorize any licensed physician,medical practitioner, hospital, clinic or othermedical or medically-related facility, insurance company, the Medical Information Bureau or other organization,institution or person, that has any records or knowledge of me or my health, to give to Fidelity Security Life Insurance Company or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. A photographic copyof this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date shown below.

Applicant's Signature ____________________ Today's Date (month/day/year) ____________

'. Payroll Deduction Authorization to ASEA:

I understand that, hereafter, the regularmonthlypremiums will be deducted from my paycheck.

Signed ____________________ Date ____________

Department/Agency:	Social Security No.	Division:	Home Phone No.:	Date Employed:	Work Phone No.:
			( )		( )

Send no money now — Remember, you have 30 days to examine your policy before paying for it! If you decide against keeping it, return your policy with no questions asked.

Act Now — Return your completed Enrollment Form today, while you're thinking aboutit. You'll be glad you took the time to prepare for the future.

Questions? Call the ASEA Insurance Office at (334) 834-6965 or toll-free (800) 252-7063

Mail your completed Enrollment Form in the postage-paid envelope to: ASEA Life Insurance Program,110 North Jackson Street, Montgomery, AL36177-9727

i. Complete for $100,000 or larger plan:

	Yes	No
a. Have you used any tobacco products during the last 12 months?	☐	☐
b. Have you ever had life or health insurance declined,modified or rated up?	☐	☐
c. Are you now taking medication or receiving medical attention?	☐	☐
d. Have you been confined in the last 5 years to a hospital or othermedical facility or seen a doctor for any reason other than stated above?	☐	☐

If "yes" to any part of items 3 or 5, give details below. Use a separate sheet of paperifmore space is needed for answers.

Question No.	Person	Condition	Dates	Treatment	Name & Addresses of Doctors, Hospitals, Clinics

i. Please Sign and Date:

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I have received and read a copyof the Pre-Notice, which describes how information is obtained and used by Fidelity Security Life Insurance Company. I hereby authorize any licensed physician,medical practitioner, hospital, clinic or othermedical or medically-related facility, insurance company, the Medical Information Bureau or other organization,institution or person, that has any records or knowledge of me or my health, to give to Fidelity Security Life Insurance Company or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. A photographic copyof this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date shown below.

Applicant's Signature ____________________ Today's Date (month/day/year) ____________

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I understand that, hereafter, the regularmonthlypremiums will be deducted from my paycheck.

Signed ____________________ Date ____________

Department/Agency:	Social Security No.	Division:	Home Phone No.:	Date Employed:	Work Phone No.:
			( )		( )

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