INFORMATION SHEET

Legal Name of Group: _____
Must match name used on federal tax filings List subsidiaries/affiliates to be covered on back

Address: _____

Phone #: _____ Federal Tax I.D. #: _____ SIC #: _____
(required)

Fax #: _____ Nature of Business: _____

Contact Name: _____ Email: _____

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

Please print the names of all Owners: _____

Requested Effective Date: _____

Deductible Requested: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other: _____

Benefit Period: ☐ 52 Weeks ☐ 114 Weeks ☐ 156 Weeks ☐ Other: _____

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

Is Policy to cover: ☐ Employees Only (W-2) or ☐ Employees (W-2) and Contract Labor (1099)

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.

The Policy forms will be delivered to the group electronically unless you request in writing to receive a paper copy.

Agent Name: _____ Agent #: _____

Phone #: _____ Fax #: _____ Email: _____

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

Rev. 2015-07

Census Information Form

CENSUS INFORMATION FOR: _____ AGENT: _____

Please asterisk all employees age 70 or over

EMPLOYEE NAME	M/F	S.S. #	DETAILED JOB DESCRIPTION (JOB TITLES NOT ACCEPTABLE)	DATE OF HIRE	DATE OF BIRTH	MONTHLY SALARY*	CLASS CODE

***MONTHLY SALARY SHOULD BE ACTUAL GROSS WAGE PAID TO EACH EMPLOYEE FOR THE CALENDAR MONTH IMMEDIATELY PRECEDING THE REQUESTED EFFECTIVE DATE.**

PREPARED BY: _____ DATE: _____

SPECIAL INSURANCE SERVICES, INC.
(Hereinafter called the Company)

SINGLE CASE AGREEMENT

This section must be completed by Agent/General Agent

Agent/General Agent	Agent Number	Commission Percent*
		_____ **% (New & Renewal)**
		_____ **% (New & Renewal)**
		_____ **% (New & Renewal)**

*This should be the percent of premium

ACCOUNT NAME: _____

NUMBER OF ELIGIBLE PERSONS: _____

PLEASE READ THE REVERSE SIDE OF THIS FORM AND SIGN BELOW
(No reproductions of this form will be accepted)

AGREED: Special Insurance Services, Inc.

Signed: _____ Dated: _____

AGREED:

Agent: _____

Signed: _____ Dated: _____

Agent: _____

Signed: _____ Dated: _____

Agent: _____

Signed: _____ Dated: _____

Instructions:
The Writing Agent must complete this Agreement and submit it, along with the new business information, to the General Agent. The General Agent will complete the Agreement and forward it to Special Insurance Services. No Agent will be paid commission until he/she is appointed by the underwriting carrier.

1. The Company agrees to pay you as full remuneration for services rendered for the production of insurance premiums a commission, as listed above, on the premiums paid to the Company and received by the Company, and earned by the Company.

2. The commission provided herein shall not be payable after (a) the date on which you are no longer recognized by the employer as its Agent or Broker for this insurance; (b) the Department of Insurance has issued rules or adopted regulations affecting the commissions herein or necessitating the revision of such insurance. In the event of such contingency, this agreement shall be subject to renegotiation; (c) your ceasing to be a licensed Agent or Broker for any reason; (d) your ceasing to be an appointed Agent of the Company; (e) permanent or temporary loss of license for any reason.

3. The Agent/Broker shall receive compensation as specified for as long as the Company receives compensation at the same level as of the date of the execution of this Agreement, or until commission for all such policies is reduced by the Company. In the event of a reduction in the Company's income from levels applicable on the date of this contract, both parties agree that adjustments will be made accordingly.

4. This contract can be terminated by either party sending not less than 30 days written notice of such termination.

5. PREMIUMS AND ACCOUNTING

5.1 All premiums are to be paid directly to the Company. The Agent has no authority to alter, modify, waive or change any of the terms, rates or conditions of the Company's Master Policy or certificates, to collect renewal premium, to extend time for payment of premium, or to endorse checks payable to the Company.

5.2 The right of the Agent or any other person to receive commissions shall, at all times, be subordinate to the right of the Company to offset or apply commissions against any indebtedness of the Agent to the Company. This right of offset shall include, but not be limited to, application against any liability incurred by the Company to any person by reason of the negligent or unauthorized acts committed by the Agent or any of his sub-agents or brokers. In the event commissions due hereunder are not sufficient to satisfy the debt, the Company may require immediate repayment of the debt from the Agent. An extension of time for repayment or modification of the amount due shall not waive the Company's rights hereunder.

5.3 All accounting and records of the Agent pertaining to Insurance written through the Company shall be subject to inspection and audit by the Company at any reasonable time.

6. GENERAL PROVISIONS

6.1 The Company shall not be responsible for any expenses incurred by the agent whether on the Agent's or Company's behalf. The Company shall administer the program and pay for all application forms, certificates, renewal billings and reporting forms.

6.2 Should the Company, for any reason, refund any premium on any policy or insured enrolled by any application procured by the Agent, his sub-agent or broker, the Agent shall be liable and shall make repayment of any commission paid to the Agent for the policy or application.

6.3 The assignment of commission or any other funds that may be due the Agent under this Agreement is prohibited and shall not be valid unless authorized in advance in writing by the Company. Any such authorized assignment shall at all times be subject to any and all indebtedness of the Agent to the Company.

6.4 All notices, requests, communications and demands under this Agreement shall be in writing and shall be duly given if delivered in person or sent by registered mail, postage prepaid to the party entitled to notice at the address which appears in the records of the Company.

CERTIFICATION BY POLICYHOLDER

We, _____, do hereby certify the following:

1. We have applied to the companies listed below for the coverages listed and fully understand the insurance applied for shall not be effective until the application is approved and accepted by the Company and a Contract is issued. No agent has the authority to bind coverage.

Insurance Company	**Coverage Applied For** (select one)
Fidelity Security Life Insurance Company	❑ Excess Reimbursement
	❑ Occupational Accident Insurance

2. We have reviewed, with the agent of the company whose signature appears below, the coverages, limits, terms, and exclusions of each contract.

3. We understand each of the following:

   a. This is not Workers' Compensation Insurance.

   b. **Excess Reimbursement** coverage is a reimbursement contract for certain benefits paid by us under the terms of our Employee Benefit Plan subject to the Employee Retirement Income Security Act (ERISA) or the deductible portion of our workers' compensation policy. The insurance carrier is not authorized to and does not sell workers' compensation insurance.

   c. **Occupational Accident Insurance** coverage is an employee benefit and does not insure any risk of the Policyholder. This policy is not indemnity coverage and does not protect the Policyholder from loss or damage on account of accidental injury, disease, sickness, or death of an employee. This policy is not liability insurance. No coverage offered by this policy is intended to, nor will it provide us any protection or defense against any suit which may be brought by anyone for any reason. The insurance carrier is not authorized to and does not sell workers' compensation.

   d. **There may be benefits paid under our ERISA Plan or workers' compensation policy that are not reimbursable/payable by these insurance contracts.**

   e. Changes in any ERISA or workers' compensation policy attached to the application for the insurance contract do not change the reimbursement amount or terms of the benefits of the insurance policy issued, unless such changes are consented to in writing by the insurance carrier.

   f. Special Insurance Services, Inc. (SIS) may administer the claims on behalf of the Company. Even when SIS has also been selected as the Third Party Administrator for our ERISA Plan or workers' compensation policy, there may be instances where benefits are payable under our ERISA Plan or workers' compensation policy and are not reimbursable/payable under the insurance contract issued by the Company.

   g. Any plan created by an employer to provide benefits to its employees may be subject to the Employee Retirement Income Security Act of 1974. If so, this may require certain information be filed with the regulatory authorities and communicated to our employees in a certain manner. The Company has informed us that it is an employers obligation to comply with this law.

   h. THIS IS NOT A POLICY OF WORKERS' COMPENSATION. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THE CONTRACT, AND IF THE EMPLOYER IS A NONSUBSCRIBER, THE EMPLOYER LOSES CERTAIN COMMON-LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATION ON LIABILITY THAT WOULD BE AVAILABLE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NONSUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

4. In lieu of submitting state Employment Commission reports, we verify that the payroll and census information, including adjustments, We have (and will submit) does (and will) accurately reflect the wage and employment status of our company. We understand the premium charged for the coverage is calculated from the payroll and census information we submit. We further understand that any misrepresentation of this data could result in a reduction or denial of benefits.

Signature Date	Agent's Signature Date
Title (must be signed by a corporate officer)	Agency

Level Premium Installment Option

(Complete this section only if you are requesting annual-in-advance payment method)

We hereby apply for the Level Premium Installment Option. We understand this option is only available if approved by the Company and that we will be notified in writing of such approval. We have included our last four quarterly Employment Commission reports for the Underwriter to review as a part of the approval process.

We further understand and agree to the following terms and conditions of the Level Premium Installment Option:

1. The Level Premium is a minimum and deposit premium and is fully earned by the Company;

2. An audit of our records will be conducted to determine the total premium due based on the premium rates stated in the policy;

3. We will pay any additional premium due as a result of the audit within 30 days of the date the Company invoices us for such additional premium;

4. We will pay interest of 1% per month on the amount of premium remaining unpaid 30 days after the date of the invoice for such premium;

5. We will pay any costs the Company incurs in the audit premium if we fail to pay the invoiced amount within 30 days of the date of the invoice. (These include, but are not limited to, collection agency fees, legal fees, and court costs.)

Signature Date	Agent's Signature Date
Title (must be signed by a corporate officer)	Agency

AGENT DISCLAIMER

RE: Corporate Accident for Responsible Employers
Fidelity Security Life Insurance Company

Group Name: _____

Requested Effective Date: _____

The Corporate Accident for Responsible Employers plan has been fully explained to me and I understand that this plan covers:

_____24-Hour Accidental Bodily Injury, Business & Pleasure; or
_____Accidental Bodily Injury while on the job only;

and that certain conditions or disabilities that may be work related and compensable according to Workers' Compensation Statutes are not covered, nor are they intended to be covered under this program.

I further understand and agree that this Plan is not in lieu of and does not affect any Statutory requirements under any Workers' Compensation Insurance Laws.

I have explained to the employer the exact provisions and outline of coverages afforded by the Corporate Accident for Responsible Employers plan. I have not represented this product to be a replacement for Workers' Compensation Insurance, nor have I offered any encouragement or recommendation to the employer to discontinue any Workers' Compensation coverage.

I understand that any misrepresentation and resulting litigation expense will be my sole responsibility.

_____ _____
Agent Signature Date

_____ _____
Witnessed Date