Policy No. BB-29-A
BB-30-A

Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, MO 64111

FOR HOSPITAL CONFINEMENT
INDEMNITY COVERAGE

FLEXCARE® BRIDGE II

Mail To:

ISM Administrators
17722 Irvine Blvd. Tustin, CA 92780

PLAN INFORMATION:

As selected by the Policyholder

In Hospital Benefit Amounts:

☐ $500	☐ $1,500	☐ $3,000	☐ $6,000
☐ $750	☐ $1,750	☐ $3,500	☐ $7,000
☐ $1,000	☐ $2,000	☐ $4,000	☐ $8,000
☐ $1,250	☐ $2,500	☐ $5,000	☐ $10,000

☐ Optional Physician Benefit Rider- ☐ $15 ☐ $20
☐ Optional Wellness Benefit Rider- ☐ $100 ☐ $200 ☐ $500
☐ Optional Outpatient Benefit II – Individual/Family

☐$500/1,000	☐$750/1,500	☐$1,000/2,000
☐$1,250/2,500	☐$1,500/3,000	☐$1,750/3,500
☐$2,000/4,000	☐$2,250/4,500	☐$2,500/5,000

Cannot exceed 100% of the family amount selected for In-Hospital Benefit Amount.

AAGE ☐ **AAPE** ☐ **(Select one)**

APPLICANT INFORMATION: Please type or print in ink

Name (last, first, middle)				Sex ☐ M ☐ F
Age	Date of Birth (mm/dd/yy)	Social Security Number	Home Phone #	Work Phone #
Street Address			E-Mail	
City		State	Zip Code	
Employer		Occupation		Date of Hire
Coverage Selected: ☐ Member ☐ Member & Child		☐ Member & Spouse ☐ Member & Family		
Monthly Premium: $		Requested Effective Date of Coverage/Change:		

DEPENDENT INFORMATION

	Name (last, first, middle)	Birth Date	Sex	Social Security #
Spouse				
Child				
Child				
Child				

(Use reverse side of form if additional space is needed)

I hereby: ☐ **ENROLL**, as indicated above, for this group insurance coverage for which I am eligible or ☐ **CHANGE** information submitted on my original application. I understand and acknowledge: That no coverage will take effect for any person to be covered who is not also covered by a Major Medical/Comprehensive Policy including Coinsurance and Deductible, in force at the time of my proposed Effective Date for this coverage. That I and any of my dependents to be insured, are either currently covered under a Major Medical/Comprehensive coverage or have enrolled for Major Medical/Comprehensive coverage. That the coverage for which I am applying may contain Pre-Existing Limitations. That by applying for this insurance coverage I am enrolling as a member of the American Associations of Government or Private Employees. That the Master Policy for this coverage is issued to the American Associations of Government or Private Employees. I will receive a certificate as evidence of my insurance coverage under the policy.

Applicant's Signature ______________________ Date __________

Parent or Legal Guardian if the Applicant is Under Age 18

Agent's Signature ______________________
(where applicable by law)

APPLICANT AUTHORIZATION

Association dues of $1.00 and administrative fees of $4.00 (per month) must be added to the premium amount collected. A service charge of $20 per incomplete transaction will be imposed for NSF, Stop Pay, Closed Account or Declined credit card.

A. CREDIT CARD BILLING:

I authorize you to charge my insurance premiums, as provided to me by the insurer, on a monthly basis to the following credit card. I understand that if I wish to discontinue this authorization or if my credit card number changes, I will notify in writing ISM Administrators.

☐ MasterCard ☐ VISA

Credit Card Number | | | | | | | | | | | | | | | | | | | | |

Signature: ______________________ Expiration Date: __________ 3 Digit Security Code ______

B. ELECTRONIC FUNDS TRANSFER

I wish to have my monthly premium deducted from the checking account number shown below. I authorize my bank to withdraw the appropriate premium and fees on a monthly basis. I understand that if I wish to discontinue this authorization or my checking account number changes, I will notify ISM Administrators in writing. My personal check payment may be converted to an electronic payment processed through the Automated Clearing House Network (ACH). My payment will be reflected on my financial institution's monthly account statement as an electronic payment in the amount of my check, and will reference the check number I use to make this payment. For further information or to opt-out of the electronic check program I understand that I must call (800)488-1474 during regular business hours. **Anti-Money Laundering regulations imposed by the federal government as part of the Patriot Act prohibit the payment of insurance premiums by cashier's check or money order.**

I authorize ACH payment of initial premium in lieu of a personal check or credit card if not included with my application.

Account # ______________________ Routing # | | | | | | | | | |

Signature of Depositor: ______________________
(as it appears on checking account)

C. PAYROLL DEDUCTION (Minimum 3 Lives)

To ______________________
Employer

I hereby authorize you to deduct from my salary or wages the amount necessary to pay the required premium and fees, and to remit that amount to ISM Administrators. I request that this authorization remain in effect until such time as I withdraw it by giving written notice prior to the next premium due date.

D. DIRECT BILL: (annual only)

Insured's Name: ______________________

Billing Address: ______________________ City __________ State _____ Zip Code _______
(If different from the first page)

Insured's Signature:

____

AGENT INFORMATION

Writing Agent Name **(Print)**: CODE #

____

Agent Address:

____

Tax ID. (if none, Social Security Number.): ______________________

A-01026

BII 4/07

"WHERE AMERICA SAVES"

Mail application to:
Association Administrators
17722 Irvine Blvd.
Tustin, CA 92780

Phone: (714) 505-1100, Ext. 888
Toll Free: (800) 488-1474, Ext. 888
www.ismflex.com

APPLICATION FOR MEMBERSHIP

Full Name (Please print) ______________________ Soc Sec # ______________

Address ______________________ Telephone ______________

City ______________________ State _____ Zip ______________

Representative ______________________ Code # ______________

Please enroll me in:

☐ American Association of Government Employees ☐ American Association of Private Employees

($12 annually for membership)

Applicant's Signature ______________________ Date ______________

AAapp 5/04

NOT FOR PROFIT MISSOURI CORPORATIONS
Unaffiliated with the United States Federal Government

Copyright AAGE/AAPE 2004
All rights reserved