FIDELITY SECURITY LIFE INSURANCE COMPANY

ELECTION OF CONTINUED EMPLOYEE VISION INSURANCE

NOTE: Vision Insurance may be continued subject to COBRA guidelines and state continuance laws.

TO BE COMPLETED BY EMPLOYER:

Employer's Name:______________________________ Group #:_____________ Account #:____________

Name(s) of Employee and Dependent(s) eligible for contribution:____

____

Employee's Social Security #:___________________________ Date eligible for continuation:_____________

Date and reason insurance is terminating:____

Cost of insurance per month on date eligible for continuation: Employee $________ Dependent(s) $________

NOTE: Premiums are subject to change for continuing insureds for the same reasons as premiums may change for active employee insureds.

Authorized Employer's Signature____ Date__________

TO BE COMPLETED BY THE APPLICANT FOR CONTINUED INSURANCE:

Please check one:

I do not wish to continue my vision coverage. I understand that my insurance under this policy will cease as of the date eligible for continuation listed above.

I do wish to continue my vision insurance coverage. I understand that timely payment of the premium to the employer is required to keep the insurance in force. I am enclosing with this form my first premium payment, made payable to the employer.

Applicant's Signature____ Date________________

93-30442

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