



ASSURITY® LIFE INSURANCE COMPANY

Toll-free Number: (800) 276-7619, Extension 4264

AssureLINK Address: <http://assurelink.assurity.com>

Term Life

Thank you for your interest in writing business with Assurity Life Insurance Company.

To enable us to process your application more quickly, please review the following checklist:

- ✓ Use the appropriate application **for the state in which the application is to be signed.**
- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state in which the application is signed.**
- ✓ Use **age last birthday** when preparing illustrations and/or calculating insurance premiums.
- ✓ Obtain all required signatures.
- ✓ Have the proposed insured initial any changes. Corrections with white correction fluid/tape are not acceptable.
- ✓ Comply with all state regulations. Note: NAIC Model Illustration or disclosure statement must accompany this application.
- ✓ Complete **all other** pertinent and applicable forms padded together in this application.
- ✓ If faxing an application directly to the home office, fax to (877) 864-6630.
- ✓ If mailing directly to the home office, address to: Assurity Life Insurance Company
Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

To check the **status of an application**, ask **underwriting-related questions** (*including "what if" scenarios*), **call toll-free** (800) 276-7619, EXT. 4264 **or email** to underwriting@assurity.com.

Stranger-Owned Life Insurance/Investor-Owned Life Insurance (STOLI/IOLI)

Assurity Life Insurance Company position on STOLI/IOLI

Assurity Life Insurance Company does not support the use of its life insurance products in situations involving Stranger- or Investor-Owned Life Insurance. The company will take all measures necessary to identify these situations and take appropriate action to disallow these transactions. The company views STOLI/IOLI transactions as an inappropriate use of insurance in violation of its intended purpose. In addition, such use of insurance products may be illegal or in connection with illegal activity based on state laws and regulations.

Definition

Any act, practice or arrangement to initiate or facilitate the issuance of a life insurance policy for the intended benefit of a person who, at the time of the policy origination, does not have an insurable interest in the life of the insured as defined by the company's insurable interest guideline.

Actions

Safeguards and procedures are in place to identify STOLI/IOLI transactions during the underwriting and issue process. Any activities identified as being in violation of our company position will lead to action including, but not limited to, cancellation of the application or policy and termination of the producer/agent contract(s) and appointment with Assurity Life Insurance Company.



1. PROPOSED INSURED

<i>First</i> <i>Middle</i> <i>Last</i>			<i>(MM/DD/YYYY)</i>	
Legal Name			Date of Birth / /	
Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Email		Age
Home <i>Street Address</i>		<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Address				
Personal Phone No. ()	Birth State/Country		Height ft. in.	Weight lbs.
Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If YES, please list type Amount per day Last date of use (MM/DD/YYYY) / /				
Has the Proposed Insured ever used any form of marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list last date of use (MM/DD/YYYY) / /				
Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident (<i>green card</i>) status? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If the Proposed Insured has permanent resident status, please list permanent resident (<i>green card</i>) number				
If not a United States citizen, how long has the Proposed Insured been in the United States? _____				
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number:				
<i>Years</i> <i>Months</i>				
Is the Proposed Insured currently working at least 30 hours per week in primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of employment /				
Primary Employer	Employer's <i>Street Address</i> <i>City</i> <i>State</i> <i>ZIP+4</i>			
Address				
Full-time Employment	<i>Occupation</i> <i>Duties</i>	Part-time Employment	<i>Occupation</i> <i>Duties</i>	
Gross monthly income \$		If self-employed, net monthly income \$		

2. POLICYOWNER (*Policyowner is the Proposed Insured unless otherwise indicated*)

If Ownership is a trust, complete the Trust Information/Additional Beneficiary section (page 2) rather than this section.

<i>First</i> <i>Middle</i> <i>Last</i>			<i>(MM/DD/YYYY)</i>	
Legal Name			Date of Birth / /	
Social Security No.	Relationship to Insured		Birth State/Country	
Home <i>Street Address</i>	<i>City</i>	<i>State</i>	<i>ZIP+4</i>	
Address				Email
Contingent Owner's Name	<i>First</i> <i>Middle</i> <i>Last</i>	Contingent Owner's Relationship to Insured		

3. BENEFICIARIES

If Beneficiary is a trust, or if additional space is needed, complete the Trust Information/Additional Beneficiary section (page 2).

Primary Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
Contingent Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	

4. PREMIUM PAYMENT—Please indicate preference for payment type and billing frequency below

What amount was collected with this application? \$ _____		Frequency	
Type		<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly	
<input type="checkbox"/> Direct Billing <input type="checkbox"/> Automatic Bank Withdrawal		<input type="checkbox"/> Monthly (<i>not available with Direct Billing</i>)	
<input type="checkbox"/> List Billing (<i>employer</i>)			
Payor <i>First</i> <i>Middle</i> <i>Last</i>	Billing <i>Street Address</i> <i>City</i> <i>State</i> <i>ZIP+4</i>		
Name	Address		

TRUST INFORMATION/ADDITIONAL BENEFICIARY

Please complete the following sections if Ownership and/or Beneficiary is a trust (or if additional room is needed to list beneficiaries of Policy):

1. POLICYOWNER

Name of Trust	(MM/DD/YYYY) Date of Trust / /		
Name of Trustee(s)	Tax ID No.		
<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Address of Trustee(s)			

2. BENEFICIARIES

☐ Testamentary Trust (*Will*) Share % _____

☐ Living Trust (*Please complete information below.*) Share % _____

Name of Living Trust	(MM/DD/YYYY) Date of Trust / /		
Name of Trustee(s)	Tax ID No.		
<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Address of Trustee(s)			

3. ADDITIONAL BENEFICIARIES

Primary Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Social Security No.	Date of Birth (<i>MM/DD/YYYY</i>)	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Social Security No.	Date of Birth (<i>MM/DD/YYYY</i>)	Share %
			/ /	
			/ /	
			/ /	
			/ /	
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GENERAL SECTION

Please answer the following questions. If additional space is needed, attach a separate sheet of paper.

1. Does any Proposed Insured belong to or have they entered into a written agreement to become a member of the military or National Guard? ☐ Yes ☐ No

2. During the past **5 years** or within the next **12 months**:

a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured intending to fly as a pilot, crew member or student? ☐ Yes ☐ No

b. Has any Proposed Insured participated in, or intend to participate in, any of the following sports or activities? ☐ Yes ☐ No

If YES, check all that apply: ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/BASE Jumping/Hang Gliding

☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports

☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning

3. During the next **12 months**, does any Proposed Insured intend to reside or travel outside of the United States? ☐ Yes ☐ No

If YES, please explain _____

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No

If YES, please list Proposed Insured's name, amount of weight change and details: diet/better eating, exercise, childbirth, or other:

5. During the past **5 years**, has any Proposed Insured:

a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? ☐ Yes ☐ No

If YES, please explain _____

b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ Yes ☐ No

If YES, please explain _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? ☐ Yes ☐ No

If YES, please explain _____

7. During the past **5 years**, has any Proposed Insured:

a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence (DUI/DWI), or pled guilty or been convicted of any moving violations? ☐ Yes ☐ No

If YES, please explain _____

b. Been convicted of a felony? ☐ Yes ☐ No

If YES, please explain _____

8. Is any Proposed Insured currently on probation? ☐ Yes ☐ No

If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

9. Has any Proposed Insured ever filed for bankruptcy? ☐ Yes ☐ No

If YES, when? _____ Has the bankruptcy been discharged? ☐ Yes ☐ No If YES, when? _____

10. a. Does any Proposed Insured have other annuity or life insurance coverage in force? ☐ Yes ☐ No

If YES, provide details below.

b. If this insurance is issued, will it replace, modify or borrow against existing or pending annuity or life insurance coverage? ☐ Yes ☐ No

If either a or b is answered YES, complete any applicable State Replacement form.

Company Name	Type of Coverage	Amount of Coverage

11. If the Proposed Insured is a juvenile, please list the total amount of life insurance in force and pending on **all** family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
\$	\$	\$	\$	\$	\$	\$

HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 5.

1. During the past **10 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
 - a. Heart disorder, including a heart attack (*myocardial infarction*), angina, irregular heartbeat or abnormal heart rhythm (*arrhythmia*), chest pain, hypertension (*high blood pressure*), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (*TIA or mini-stroke*), or rheumatic fever? ☐ Yes ☐ No
 - b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease (*other than kidney stones*), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? ☐ Yes ☐ No
 - c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? ☐ Yes ☐ No
 - d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (*including Down syndrome*), multiple sclerosis (*MS*), muscular dystrophy (*MD*), Parkinson's disease, amyotrophic lateral sclerosis (*ALS*), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy? ☐ Yes ☐ No
 - e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (*COPD*), shortness of breath, or asthma or other respiratory disorder? ☐ Yes ☐ No
 - f. Dizziness, fainting spells or anxiety, depression, chronic fatigue, eating disorders or any other psychological or emotional disorder? ☐ Yes ☐ No
 - g. Arthritis in any form, fibromyalgia, paralysis or connective tissue disorder (*such as lupus or scleroderma*) or any disease or disorder of the back, spine, bones, joints or muscles? ☐ Yes ☐ No
 - h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? ☐ Yes ☐ No
 - i. Any disease or disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
2. During the past **10 years**, has any Proposed Insured:
 - a. Required a transfusion of whole blood or blood products, including platelets, packed red blood cells or plasma? ☐ Yes ☐ No
 - b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? ☐ Yes ☐ No
 - c. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? ☐ Yes ☐ No
 - d. Been diagnosed or treated by a medical professional for acquired immunodeficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*); or had a positive test for human immunodeficiency virus (*HIV*) antibodies? ☐ Yes ☐ No
3. During the past **5 years**, has any Proposed Insured:
 - a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? ☐ Yes ☐ No
 - b. Been advised to have any test (*except HIV tests*), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received? ☐ Yes ☐ No
 - c. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related blood tests*) or urine tests? ☐ Yes ☐ No
4. Has any Proposed Insured had a natural parent or sibling who was diagnosed by a medical professional with or died of cancer, heart disease, diabetes, Huntington's disease or polycystic kidney disease prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death. ☐ Yes ☐ No

5.
 - a. Has any Proposed Insured **ever** been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No
 - b. Is any Proposed Insured currently pregnant? ☐ Yes ☐ No
 If YES, date child is expected (MM/DD/YYYY) ____ / ____ / ____
6. Is any Proposed Insured currently taking any prescription medication? ☐ Yes ☐ No

DETAILS: Enter complete details from question numbers 1-6 on page 5. If more space is needed, attach additional Supplemental Information form.

SUPPLEMENTAL INFORMATION

Question #/Letter	Name (First, Middle, Last)	Onset Date (MM/DD/YYYY)	Duration (Days, Mos, Yrs)	Health Condition and Details	Medical Care Provider's Name/Address/Phone
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Additional Information:

LIFE PRODUCT SECTION

1. What is the purpose of this insurance? ☐ Personal ☐ Key Person ☐ Buy/Sell ☐ Business Loan ☐ Charitable Giving ☐ Other _____
2. a. Are there any agreements in place to assign/sell the policy? _____ ☐ Yes ☐ No
- b. Is there any intent to sell the policy after issuance? _____ ☐ Yes ☐ No
- c. Has the insured undergone any life expectancy or health exams in conjunction with a life insurance application or settlement option contract? ☐ Yes ☐ No

TERM LIFE INSURANCE

Face Amount \$ _____ Number of years for policy: ☐ 10-Year ☐ 15-Year ☐ 20-Year ☐ 30-Year

ADDITIONAL BENEFITS AVAILABLE ON TERM LIFE—Check benefit(s) desired and indicate amount requested where applicable.

- | | |
|---|--|
| <input type="checkbox"/> Disability Waiver of Premium Rider | <input type="checkbox"/> Other Insured Level Term Rider
(complete next page) \$ _____ |
| <input type="checkbox"/> Monthly Disability Income Rider for Primary Insured \$ _____ mo. benefit | <input type="checkbox"/> Monthly Disability Income Rider for Other Insured (complete next page) \$ _____ mo. benefit |
| <input type="checkbox"/> Accident Only Disability Income Rider for Primary Insured \$ _____ mo. benefit | <input type="checkbox"/> Accident Only Disability Income Rider for Other Insured (complete next page) \$ _____ mo. benefit |
| <input type="checkbox"/> Critical Illness Benefit Rider for Primary Insured \$ _____ | <input type="checkbox"/> Critical Illness Benefit Rider-Other Insured (complete next page) \$ _____ |
| <input type="checkbox"/> Children's Term Rider (complete next page) _____ units | <input type="checkbox"/> Endowment Benefit Rider |

WHOLE LIFE INSURANCE

Face Amount \$ _____

If cash value is available, should the Automatic Premium Loan (APL) provision be made effective? (If no option chosen, APL will apply.) ☐ Yes ☐ No

Nonforfeiture Option: (If no option chosen, ETI will apply) ☐ Extended Term Insurance (ETI) ☐ Reduce Paid-Up Insurance (RPU)

Dividend Option: (If no option chosen, PUA will apply) ☐ Paid-up Additions (PUA) ☐ Accumulate at Interest ☐ Reduce Premium/PUA
☐ Reduce Premium/Cash ☐ Paid in Cash

ADDITIONAL BENEFITS AVAILABLE ON WHOLE LIFE—Check benefit(s) desired and indicate amount requested where applicable.

- | | |
|--|--|
| <input type="checkbox"/> Disability Waiver of Premium Benefit Rider | <input type="checkbox"/> Protected Insurability Benefit Rider \$ _____ |
| <input type="checkbox"/> Monthly Disability Income Rider for Primary Insured \$ _____ mo. benefit | <input type="checkbox"/> Monthly Disability Income Rider for Other Insured (complete next page) \$ _____ mo. benefit |
| <input type="checkbox"/> Accident Only Disability Income Rider for Primary Insured \$ _____ mo. benefit | <input type="checkbox"/> Accident Only Disability Income Rider for Other Insured (complete next page) \$ _____ mo. benefit |
| <input type="checkbox"/> Critical Illness Benefit Rider for Primary Insured \$ _____ | <input type="checkbox"/> Critical Illness Benefit Rider-Other Insured (complete next page) \$ _____ |
| <input type="checkbox"/> Children's Term Insurance Rider (complete next page) _____ units | <input type="checkbox"/> Accidental Death Benefit Rider \$ _____ |
| <input type="checkbox"/> Level Term Insurance Benefit Rider for Primary Insured (Select only one): | <input type="checkbox"/> 10-Year <input type="checkbox"/> 20-Year \$ _____ |
| <input type="checkbox"/> Level Term Insurance Benefit Rider — Other Insured (Select only one): | <input type="checkbox"/> 10-Year <input type="checkbox"/> 20-Year \$ _____ |
| <input type="checkbox"/> Payor Benefit Rider (Complete Health Section for Payor) Payor Name _____ DOB ____ / ____ / ____ <input type="checkbox"/> M <input type="checkbox"/> F | |
| <input type="checkbox"/> Paid-Up Additions Purchase Option (VER) <input type="checkbox"/> Periodic Premiums \$ _____ <input type="checkbox"/> Single Premium \$ _____ | |

SINGLE PREMIUM WHOLE LIFE INSURANCE

Face Amount \$ _____ ☐ Single Premium Insurance Rider \$ _____

Dividend Option: (If no option chosen, PUA will apply) ☐ Paid-Up Additions (PUA) ☐ Paid in Cash

LIFE PRODUCT SECTION (continued)

OTHER INSURED AND CHILD RIDER INFORMATION—If additional space is needed, attach a separate sheet of paper.

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name (First, Middle, Last)				
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Proposed Insured				
Employer and Occupation/Duties		1. Has any proposed insured child ever : a. Been diagnosed with or treated for internal cancer or tumor, lymphoma, leukemia, disorder of the lymph nodes or glandular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Been diagnosed with or treated for heart disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. During the past 5 years , has any proposed insured child been advised by a member of the medical profession to have any diagnostic tests performed but not completed, or for which the results are currently unknown or pending (excluding HIV tests)? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES to any of the above, please list child(ren)'s name(s): _____		
Personal Phone No.				
Gross monthly income	\$			
If self-employed, net monthly income	\$			
Has the Other Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? <input type="checkbox"/> Yes <input type="checkbox"/> No (Not applicable to Child Riders.)				
If YES, please list type _____ Amount per day _____ Last date of use (MM/DD/YYYY) ____/____/____				
Has the Other Insured ever used any form of marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list last date of use (MM/DD/YYYY) ____/____/____				
Is the Other Insured a United States citizen, or does the Other Insured have permanent resident (green card) status? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If the Other Insured has permanent resident status, please list permanent resident (green card) number. _____				
If the Other Insured is not a United States citizen, how long has the Other Insured been in the United States? _____				
Does the Other Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number. _____				
Please list the last physician consulted by the Other Insured: Is this your primary physician? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name _____ Date last consulted ____/____/____ MM/DD/YYYY				
Address _____ Street Address Suite City State ZIP+4				
Phone No. (____) _____ Fax No. (____) _____				
Reason for consultation _____				
Results _____				

UNIVERSAL LIFE PRODUCT SECTION

1. What is the purpose of this insurance? ☐ Personal ☐ Key Person ☐ Buy/Sell ☐ Business Loan ☐ Charitable Giving ☐ Other _____
2. a. Are there any agreements in place to assign/sell the policy? ☐ Yes ☐ No
- b. Is there any intent to sell the policy after issuance? ☐ Yes ☐ No
- c. Has the insured undergone any life expectancy or health exams in conjunction with a life insurance application or settlement option contract? ☐ Yes ☐ No

Face Amount \$ _____ ☐ Option 1 – Level ☐ Option 2 – Accumulating (If no option is selected, Option 1 will apply.)

Planned Periodic Premium \$ _____ Special Policy Date (if desired) ____ / ____ / ____

ADDITIONAL BENEFITS

Check rider(s) desired and indicate amount requested.

PRIMARY INSURED RIDERS

- ☐ Level Term Rider \$ _____ face amt.
☐ 10 years ☐ 20 years
- ☐ Critical Illness Rider \$ _____ benefit amt.
- ☐ Accident-only Disability Income Rider \$ _____ mo. benefit
- ☐ Disability Income Rider \$ _____ mo. benefit
- ☐ Face Amount Increase Rider \$ _____ face amt.
- ☐ Accidental Death Rider
- ☐ Disability Waiver Rider

OTHER INSURED RIDERS

- ☐ Other Insured Level Term Rider \$ _____ face amt.
☐ 10 years ☐ 20 years
- ☐ Other Insured Critical Illness Rider \$ _____ benefit amt.
- ☐ Accident-only Disability Income Rider \$ _____ mo. benefit
- ☐ Disability Income Rider \$ _____ mo. benefit

CHILD(REN) INSURED RIDER

- ☐ Children's Term Rider _____ units

OTHER INSURED AND CHILD RIDER INFORMATION—If additional space is needed, attach a separate sheet of paper.

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name (First, Middle, Last)				
Date of Birth (MM/DD/YYYY)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
Age				
Social Security No.				
Birth State/Country				
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Proposed Insured		1. Has any proposed insured child ever : a. Been diagnosed with or treated for internal cancer or tumor, lymphoma, leukemia, disorder of the lymph nodes or glandular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Been diagnosed with or treated for heart disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. During the past 5 years , has any proposed insured child been advised by a member of the medical profession to have any diagnostic tests performed but not completed, or for which the results are currently unknown or pending (excluding HIV tests)? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES to any of the above, please list child(ren)'s name(s): _____ _____		
Employer and Occupation/Duties				
Personal Phone No				
Gross monthly income	\$ _____			
If self-employed, net monthly income	\$ _____			

OTHER INSURED INFORMATION (continued)—If additional space is needed, attach a separate sheet of paper.

Has the Other Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ☐ Yes ☐ No

If YES, please list type _____ Amount per day _____ Last date of use (MM/DD/YYYY) ____ / ____ / ____

Has the Other Insured ever used any form of marijuana? ☐ Yes ☐ No If YES, please list last date of use (MM/DD/YYYY) ____ / ____ / ____

Is the Other Insured a United States citizen, or does the Other Insured have permanent resident (*green card*) status? ☐ Yes ☐ No

If the Other Insured has permanent resident status, please list permanent resident (*green card*) number. _____

If the Other Insured is not a United States citizen, how long has the Other Insured been in the United States? _____

Does the Other Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number. _____

Please list the last physician consulted by the Other Insured: Is this your primary physician? ☐ Yes ☐ No

Name _____ Date last consulted ____ / ____ / ____
MM/DD/YYYY

Address _____
Street Address Suite City State ZIP+4

Phone No. () Fax No. ()

Reason for consultation _____

Results _____

PHYSICIAN INFORMATION

Please list the last physician consulted:

Name _____ Date last consulted / /
MM/DD/YYYY

Address _____
Street Address Suite

City

State

ZIP+4

Phone No. () Fax No. ()

Is this your primary physician? ☐ Yes ☐ No

Reason for consultation _____

Results _____

AGREEMENT

I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief. I (We) agree that this application shall form a part of the policy if attached thereto.

I (We) agree that:

- a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.
- b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and the answers on the application remain true, complete and accurate as of the date the first full premium is paid. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.
- d. If the Policyowner is someone other than the Insured, in the event of the Policyowner's death (and no Contingent Owner(s) living), the Insured will become the Policyowner.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Substitute Form W-9 information (Request for Taxpayer Identification Number and Certification): I, the Owner (or each Joint Owner), certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____
City State

on / /
Date (MM/DD/YYYY)

Signature of Proposed Insured

Signature of Additional Proposed Insured

Signature of Parent/Guardian of Minor Child

Signature of Additional Proposed Insured

Signature of Owner(s) (If other than Proposed Insured)

Signature of Licensed Agent

Print Agent Name and Agent No.

AGENT STATEMENT			
1.	a. Has a Temporary Conditional Insurance Agreement been given to the Policyowner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	a. Did you personally see each Proposed Insured on the date of application?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. How well do you know the Proposed Insured(s)? <input type="checkbox"/> Well <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all		
	c. Did the Proposed Insured approach you to purchase insurance? If YES, list their stated need for the insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	d. Did the Proposed Insured(s) directly respond to you regarding each application question?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	e. Was a government-issued picture ID requested and reviewed for the Proposed Insured, Owner and Payor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	f. Was each Proposed Insured present, and did you witness their signatures at the time the application was taken?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	g. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured(s)? If YES, please provide details below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Agent is responsible for scheduling exam items.			
NOTE: ANY PREFERRED PLANS REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.			
<input type="checkbox"/> Paramedical examination <input type="checkbox"/> Blood sample <input type="checkbox"/> Urine sample <input type="checkbox"/> Electrocardiogram (EKG) <input type="checkbox"/> Medical exam by physician			
4.	Is other insurance coverage in force for any Proposed Insured?		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	If this insurance is issued, will it replace, modify or borrow against existing or pending coverage?		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Was sales material used in soliciting this application?		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Was the sales material left with the applicant?		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Was the sales material approved by Assurity Life Insurance Company?		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Are commissions to be split? <input type="checkbox"/> Yes <input type="checkbox"/> No Agent Name _____ Agent's No. _____ %		
	Agent Name _____ Agent's No. _____ %		

☐ Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.

☐ Add to existing bank withdrawal—indicate other applicant and/or policy numbers _____

☐ Set up NEW credit card payment—submit signed authorization with the application.

☐ Set up NEW list bill—submit signed employer authorization form with the application.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

<p>The premiums for this application were quoted on the following underwriting classification:</p> <p><input type="checkbox"/> Preferred Plus NT <input type="checkbox"/> Preferred NT <input type="checkbox"/> Standard NT <input type="checkbox"/> Preferred T <input type="checkbox"/> Standard T</p>	<p>Other Insured's underwriting classification:</p> <p>_____</p>
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<p>The premiums for this application were quoted on the following underwriting classification:</p> <p> <input type="checkbox"/> Preferred Plus NT <input type="checkbox"/> Preferred NT <input type="checkbox"/> Select NT <input type="checkbox"/> Preferred T <input type="checkbox"/> Standard T </p>	<p>Other Insured's underwriting classification:</p> <p>_____</p>
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The premiums for this application were quoted on the following underwriting classification: <input type="checkbox"/> Preferred Plus NT <input type="checkbox"/> Preferred NT <input type="checkbox"/> Select NT <input type="checkbox"/> Preferred T <input type="checkbox"/> Standard T	Other Insured's underwriting classification: _____
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Signature of Soliciting Agent

Date (MM/DD/YYYY)

Business Phone No. and Fax No.

Soliciting Agent's Printed Name	Agent No.	Agent's E-mail
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**ASSURITY® LIFE INSURANCE COMPANY**

Post Office Box 82533, Lincoln, NE 68501-2533

(402) 476-6500 • (800) 276-7619 • www.assurity.com

Confidential Information Authorization_____
*Legal Name of Applicant/Insured/Claimant (Please print)*____/____/____
*Date of Birth (MM/DD/YYYY)*_____
*Legal Name of Additional Applicant/Insured/Claimant (Please print)*____/____/____
Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

*Legal Name**Date of Birth**Legal Name**Date of Birth*

_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. (*formerly known as the Medical Information Bureau*), or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company (*Assurity*), or its reinsurers, any such information. This may include:

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions (*start and stop times*), the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four (24) months from the date of signature below (**authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

____/____/____
*Date (MM/DD/YYYY)*_____
*Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*_____
*Signature of Additional Applicant/Insured/Claimant or Legal Representative*_____
*Signature of Applicant/Insured/Claimant Child (if age 18 or older)*_____
*Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)***ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT**

**ASSURITY® LIFE INSURANCE COMPANY**

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Confidential Information Authorization_____
*Legal Name of Applicant/Insured/Claimant (Please print)*____/____/____
*Date of Birth (MM/DD/YYYY)*_____
*Legal Name of Additional Applicant/Insured/Claimant (Please print)*____/____/____
Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

*Legal Name**Date of Birth**Legal Name**Date of Birth*

_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. (*formerly known as the Medical Information Bureau*), or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company (*Assurity*), or its reinsurers, any such information. This may include:

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions (*start and stop times*), the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four (24) months from the date of signature below (**authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

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____/____/____
*Date (MM/DD/YYYY)*_____
*Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*_____
*Signature of Additional Applicant/Insured/Claimant or Legal Representative*_____
*Signature of Applicant/Insured/Claimant Child (if age 18 or older)*_____
*Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)***ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT**



Legal Name of Applicant/Insured/Claimant (Please print)

Date of Birth (MM/DD/YYYY)

Legal Name of Additional Applicant/Insured/Claimant (Please print)

Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name

Date of Birth

Legal Name

Date of Birth

_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. (*formerly known as the Medical Information Bureau*), or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company (*Assurity*), or its reinsurers, any such information. This may include:

- Psychotherapy notes

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twelve (12) months from the date of signature below, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

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Date (MM/DD/YYYY)

Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

Signature of Additional Applicant/Insured/Claimant or Legal Representative

Signature of Applicant/Insured/Claimant Child (if age 18 or older)

Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT





Legal Name of Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Legal Name of Additional Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name

Date of Birth

Legal Name

Date of Birth

_____	_____	_____	_____
_____	_____	_____	_____

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- Psychotherapy notes

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By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twelve (12) months from the date of signature below, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

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_____/_____/_____
Date (MM/DD/YYYY)

Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

Signature of Additional Applicant/Insured/Claimant or Legal Representative

Signature of Applicant/Insured/Claimant Child (if age 18 or older)

Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT





MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Assurity or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (*TTY 866-346-3642*). If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, Assurity will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices, please direct your requests to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended (*15 U.S.C. 1681d*), notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, Assurity Life Insurance Company (*Assurity*) may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation Assurity requests. Please direct this written request to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Upon receipt of such a request, Assurity will respond by mail within five business days.

Telephone Interview Information

Assurity may require that you complete a confidential telephone interview as a part of your application for insurance. The interview will be conducted by a trained professional and may include (*but is not limited to*) the following topics: occupation, job history, income, personal and business financial information and medical history. All information obtained will be used for underwriting purposes only and will not be released without your written consent.





ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Temporary Conditional Insurance Agreement

(for use with Life and Reversionary Annuity products)

Please make premium check(s) payable to Assurity Life Insurance Company. Do not make checks payable to the agent. Do not leave the check payee blank.

This Temporary Conditional Insurance Agreement is void if altered or modified. No agent is authorized to change or waive any terms, conditions or limitations stated herein.

Proposed Insured No. 1 _____ Date Application Signed ____ / ____ / ____

Proposed Insured No. 2 _____ Date Application Signed ____ / ____ / ____

TERMS AND CONDITIONS

In consideration of \$ _____ in premium received by Assurity Life Insurance Company (*Assurity*) for an insurance Policy on the life of the Proposed Insured(s), and subject to the limitations stated herein, insurance will become effective under this Temporary Conditional Insurance Agreement (*Agreement*) if all of the terms and conditions stated below are fulfilled exactly. The effective date (*Effective Date*) of coverage under this Agreement will be the later of: i) the date of application; or ii) the date any medical examination of the Proposed Insured(s) is completed, if required by Assurity.

Subject to the limitations below, insurance will become effective under this Agreement on the Effective Date if the following conditions are fulfilled exactly:

1. The first full premium has been paid and the check is honored on first presentation for payment;
2. The application and any required medical examination(s) are completed in full;
3. On the Effective Date, all statements given in the application are true and complete;
4. On the Effective Date, the Proposed Insured(s) is insurable at Assurity's **standard or better than average rates** (*no ratings included*), according to Assurity's underwriting practices for the amount of insurance and any additional benefits applied for; and
5. The Policy is issued by Assurity exactly as applied for within 90 days from the date of application, delivered and accepted by the Proposed Insured(s).

Except as stated herein, coverage under this Agreement is subject to the same terms, including any limitations and exclusions, which would be part of the Policy if issued as applied for.

MAXIMUM AMOUNT LIMITATION

Assurity's maximum liability under this Agreement shall not exceed the amount of \$500,000 if the Proposed Insured(s) is within ages 15 days through 69 years, or \$250,000 if the Proposed Insured(s) is within ages 70 through 75, reduced by the face amount of any life insurance and by the present value of any reversionary annuity then in force or pending with Assurity. These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.

REFUND OF PAYMENT

There will be no insurance coverage under this Agreement, and Assurity's liability will be limited to a return of the premium submitted if:

- The Policy applied for is not issued within 90 days of the date of application;
- Any of the terms or conditions set forth in this Agreement are not satisfied;
- The Proposed Insured(s) dies by suicide; or
- The application contains a material misrepresentation to Assurity.

Dated at _____
City, State

On _____
Date (MM/DD/YYYY)

Signature of Proposed Insured No. 1

Signature of Proposed Insured No. 2

Signature of Agent or Witness (disinterested person)

Print Agent or Witness Name

Signature of Owner (if other than Proposed Insured)





Please make premium check(s) payable to Assurity Life Insurance Company. Do not make checks payable to the agent. Do not leave the check payee blank.

This Temporary Conditional Insurance Agreement is void if altered or modified. No agent is authorized to change or waive any terms, conditions or limitations stated herein.

Proposed Insured No. 1 _____ Date Application Signed ____ / ____ / ____

Proposed Insured No. 2 _____ Date Application Signed ____ / ____ / ____

TERMS AND CONDITIONS

In consideration of \$ _____ in premium received by Assurity Life Insurance Company (*Assurity*) for an insurance Policy on the life of the Proposed Insured(s), and subject to the limitations stated herein, insurance will become effective under this Temporary Conditional Insurance Agreement (*Agreement*) if all of the terms and conditions stated below are fulfilled exactly. The effective date (*Effective Date*) of coverage under this Agreement will be the later of: i) the date of application; or ii) the date any medical examination of the Proposed Insured(s) is completed, if required by Assurity.

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1. The first full premium has been paid and the check is honored on first presentation for payment;
2. The application and any required medical examination(s) are completed in full;
3. On the Effective Date, all statements given in the application are true and complete;
4. On the Effective Date, the Proposed Insured(s) is insurable at Assurity's **standard or better than average rates** (*no ratings included*), according to Assurity's underwriting practices for the amount of insurance and any additional benefits applied for; and
5. The Policy is issued by Assurity exactly as applied for within 90 days from the date of application, delivered and accepted by the Proposed Insured(s).

Except as stated herein, coverage under this Agreement is subject to the same terms, including any limitations and exclusions, which would be part of the Policy if issued as applied for.

MAXIMUM AMOUNT LIMITATION

Assurity's maximum liability under this Agreement shall not exceed the amount of \$500,000 if the Proposed Insured(s) is within ages 15 days through 69 years, or \$250,000 if the Proposed Insured(s) is within ages 70 through 75, reduced by the face amount of any life insurance and by the present value of any reversionary annuity then in force or pending with Assurity. These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.

REFUND OF PAYMENT

There will be no insurance coverage under this Agreement, and Assurity's liability will be limited to a return of the premium submitted if:

- The Policy applied for is not issued within 90 days of the date of application;
- Any of the terms or conditions set forth in this Agreement are not satisfied;
- The Proposed Insured(s) dies by suicide; or
- The application contains a material misrepresentation to Assurity.

Dated at _____
City, State

On _____
Date (MM/DD/YYYY)

Signature of Proposed Insured No. 1

Signature of Proposed Insured No. 2

Signature of Agent or Witness (disinterested person)

Print Agent or Witness Name

Signature of Owner (if other than Proposed Insured)





BLOOD TESTING MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

INSURER: Assurity Life Insurance Company • P.O. Box 82533 • 1526 K Street • Lincoln, Nebraska 68501-2533

EXAMINER: _____

Name

Address

To determine your insurability, the Insurer named above (*the Insurer*) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (*HIV*), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (*fats*) and screening for liver or kidney disorders, diabetes, and immune disorders.

PRE-TESTING CONSIDERATION

Many public health organizations have recommended that before taking an AIDS virus (*HIV*) antibody/antigen test, a person seek counseling to become informed concerning the implications of such tests. You may wish to consider counseling, at your own expense, prior to being tested.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved in the underwriting and claims review process. If the HIV test is positive, the results will be reported to the local health department or the State Department of Health and if the Insurer is a member of the Medical Information Bureau (*MIB, Inc.*), the Insurer may report the results in a generic code which signifies only nonspecific blood test abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or authorized by you.

The following protocol will be used for blood testing:

- 1) An initial ELISA blood test.
- 2) If the initial ELISA test is positive, then a repeat ELISA blood test must be given.
- 3) If the second ELISA blood test is positive, a Western Blot test must be used to confirm the previous positive results. If any of the tests yield negative results, the tests may not be used for underwriting and the positive result(s) must be purged from your insurance file.

MEANING OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer or your designated physician will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal medical authorities have concluded that persons who are HIV antibody/antigen-positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.



CONSENT

I have read and I understand this Notice of Consent for Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood and the disclosure of the test results as described above.

In the event of a positive HIV test result, I authorize Assurity Life Insurance Company to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

Physician's Name _____

Physician's Address _____

This form will be valid for 30 months from the date it is signed, as designated below.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (Print)

Date of Birth
(MM/DD/YYYY)

Signature of Proposed Insured or Parent/Guardian
or Other Authorized Representative

Date Signed
(MM/DD/YYYY)

State of Residence





IMPORTANT NOTICE

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by withdrawal, surrender or borrowing of some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs, and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

Please list each existing policy or contract that you are contemplating replacing (*include the name of the insurer, the insured or annuitant, and the policy or contract number if available*) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>

Make sure you know the facts. Contact your existing company or its producer for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer. Ask for and retain all sales material used by the producer in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

I certify that the responses herein are, to the best of my knowledge, accurate:

<hr/>	<hr/>
<i>Applicant's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>

<hr/>	<hr/>
<i>Producer's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>

Signed form to be returned to the home office.

Applicant to receive a copy of the signed form at the time the application is taken.



I do not want this notice read aloud to me. _____ (*Applicant must initial only if they do not want the notice read aloud.*)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or producer that sold you your existing policy or contract to provide you with information. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your producer to determine whether replacement or financing your purchase makes sense:

PREMIUMS

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur acquisition costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (*See your tax advisor.*)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

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ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

**Automatic
PREMIUM PAYMENT**
PLEASE PRINT WITH BLACK INK

Name of Proposed Insured _____
First Middle Last

By my signature below, I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska (*hereafter referred to as Assurity*), to initiate drafts to my account listed for premiums as selected. I understand that initiating automatic payments may result in additional drafts to bring my account current. I also understand that if the day selected falls on a weekend, my account may be charged on the next business day. This authorization shall remain in effect until revoked by me in a manner provided by law. Until such notice of revocation is received, I agree that Assurity shall be fully protected in requesting any draft to my account. I further understand that if the day of the draft is after the policy issue date and the payment for premium is not honored, my policy may lapse and require evidence of insurability for reinstatement. The initial premium payment will be applied only if and when Assurity has approved the application for issue and all policy requirements have been fulfilled. No coverage will be in force until the premium is paid.

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

Day of Withdrawal _____. Withdrawal day **cannot** be the 29th, 30th or 31st. If no day is entered, the policy issue date will be used. Assurity will begin processing your bank draft on the day selected. Due to the bank's processing time, the actual day a withdrawal is posted to your account could be two or more days after the day selected.

Please choose an initial premium payment option: (*If no option is selected, the initial and recurring premium payments will be drafted from your account.*)

☐ Draft the **initial and recurring** premium payments.

☐ Draft **recurring** premium payments only. Initial premium payment will be paid by: ☐ Payment enclosed or ☐ Payment collected on delivery

Type of Account: ☐ Checking ☐ Savings

Name of Financial Institution Routing No. (9-digit number) Account No.

Account Holder's Printed Name (if other than Proposed Insured/Owner) Relationship (if other than Proposed Insured/Owner)

Account Holder's Address (Street Address, P.O. Box, City, State, Zip+4) Name of Authorized Officer (if any)

Signature of Account Holder or Authorized Officer / / ()
Date (MM/DD/YYYY) Telephone No.

TO ENSURE ACCURACY, SUBMIT VOIDED CHECK
(*unless application is submitted electronically*)