ASSURITY® LIFE INSURANCE COMPANY
Toll-free Number: (800) 276-7619, Extension 4264
AssureLINK Address: http://assurelink.assurity.com

Simplified Disability Income

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:

- ✓ If the proposed insured has a history of heart trouble, stroke or cancer — do not collect the initial premium.
- ✓ The proposed insured and the policy owner must be the same person.
- ✓ The application should coincide with the **state in which the policy owner resides** for the following states:
  - MT and NJ

  All other applications should coincide with **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 coinciding with the application used.**
- ✓ 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.
- ✓ 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.

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

Application for INSURANCE

PLEASE PRINT WITH BLACK INK

PROPOSED INSURED

Legal Name (*First, Middle, Last*) | Date of Birth (*MM/DD/YYYY*) / /

Social Security No. | ☐ Male ☐ Female | E-mail | Age

Home Address (*Street Address, City, State, ZIP+4*)

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? ..... ☐ Yes ☐ No

If YES, please list type: and last date of use (*MM/DD/YYYY*): / /

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

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

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No Length of employment? (*Years / Months*) /

Primary Employer | Employer's Address (*Street Address, City, State, ZIP+4*)

Full-time Employment (*Occupation, Duties*) | Part-time Employment (*Occupation, Duties*)

Gross monthly income $ | If self-employed, net monthly income $

BENEFICIARY

Beneficiary Name (*First, Middle, Last*)	Relationship to Insured	Social Security No.	Date of Birth (*MM/DD/YYYY*)
			/ /

PREMIUM PAYMENT MODE

☐ Annual ☐ Semi-Annual ☐ Quarterly

☐ Monthly (*Automatic Bank Withdrawal*) ☐ ~~Monthly (Credit Card)~~ ☐ List Bill

GENERAL SECTION

1. During the past **5 years** or within the next **12 months** (*If YES to any of the following, please complete and return the Avocation Questionnaire*):
   a. Has the Proposed Insured flown, or is the Proposed Insured planning to fly, as a pilot, crew member or student? ..... ☐ Yes ☐ No
   b. Has the Proposed Insured participated in, or is the Proposed Insured planning to participate in any hazardous sport or activities? ..... ☐ Yes ☐ No
   If YES, check all that apply: ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/Hang Gliding ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning
2. During the past **5 years**, has the Proposed Insured had their driver's license suspended or revoked, been convicted of or pleaded "guilty" or "no contest" to driving under the influence (*DUI/DWI*) or had more than 3 moving violations? ..... ☐ Yes ☐ No
   If YES, please explain: _____
3. Is the Proposed Insured currently on probation? ..... ☐ Yes ☐ No
   If YES, please list reason for probation and length of probationary period: _____
4. During the past **2 years**, has the Proposed Insured been declined for disability or life coverage? ..... ☐ Yes ☐ No
   If YES, please explain: _____
5. Is the Proposed Insured currently negotiating for other insurance coverage? ..... ☐ Yes ☐ No
   If YES, please explain: _____
6. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ..... ☐ Yes ☐ No
   If YES, please complete and return the appropriate State Replacement Form.
7. Does the Proposed Insured have other disability income insurance coverage in force? If YES, please provide details below. ..... ☐ Yes ☐ No

Company Name	Policy No.	Business (*B*) Personal (*P*)	Monthly Benefit and Benefit Period	Issue Date (*MM/DD/YYYY*)	Coordinates with Social Security?	Employer Paid?
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No

HEALTH SECTION

1. During the past 5 years, has the Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, any of the following:
   a. Mental or nervous system disorder, depression, chest pain, or disease or disorders of the joints, muscles or spine? ☐ Yes ☐ No
   b. Alcoholism, drug addiction or other substance abuse, or had a positive test for an illegal drug? ☐ Yes ☐ No
   c. Any disease or disorder of the stomach, intestines, bowel, rectum, appendix, liver, pancreas, thyroid, urinary system or gallbladder? ☐ Yes ☐ No
2. Has the Proposed Insured **ever** had or been advised to have an organ or tissue transplant, or consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, any of the following: disease or disorder of the heart *(including heart attack, heart condition, congestive heart failure, heart valve disorder)*, circulatory system *(including peripheral vascular disease, carotid artery disease)*, kidneys, liver *(excluding hepatitis A)*, lungs or respiratory system *(including emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea)*; Alzheimer's disease; dementia; high blood pressure; insulin dependent diabetes; Hodgkin's disease; internal cancer; leukemia; lymphoma; melanoma; multiple sclerosis *(MS)*; muscular dystrophy *(MD)*; systemic lupus erythematosus *(SLE)*; stroke; or transient ischemic attack *(TIA or mini-stroke)*? ☐ Yes ☐ No
3. Has the Proposed Insured **ever** been diagnosed or treated by a medical professional for acquired immune deficiency 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
4. Has the Proposed Insured been advised to have surgery, treatment or testing which has not been completed or for which results have not been received? ☐ Yes ☐ No
5. Has the Proposed Insured **ever** needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing or dressing)*? ☐ Yes ☐ No
6. Is the Proposed Insured currently pregnant? If YES, date child is expected *(MM/DD/YYYY)* __/__/____ ☐ Yes ☐ No
   If YES, during this or any prior pregnancy, has there been a history of pregnancy-related complications? ☐ Yes ☐ No
7. Is the Proposed Insured currently taking prescription medication? ☐ Yes ☐ No
8. DETAILS: Enter complete details from questions #1-7 below. If additional space is needed, attach a separate sheet of paper.

Question #/Letter	Date of Condition *(MM/DD/YYYY)*	Health Condition & Details	Prescription Medication(s)	Medical Care Provider's Name/Address/Phone
	/ /			
	/ /			
	/ /			

9. Critical Illness Benefit Rider only—Have two or more of the Proposed Insured's natural parents, brothers or sisters *(either living or deceased)* been diagnosed with the same conditions from the following list: heart disease, stroke, diabetes or the same type of cancer prior to age 55? ☐ Yes ☐ No

DISABILITY INCOME PRODUCT SECTION

1. a. Occupation Class: ☐ 1 ☐ 2
   b. Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days
   c. Benefit Period: ☐ 6 months ☐ 1 year ☐ 2 years
   d. Monthly Base Amount ~~*(maximum $2,500)*~~: $_____
2. Additional Benefits: Critical Illness Benefit Rider ☐ $5,000 ☐ $10,000 ☐ Retroactive Injury Benefit Rider ☐ Return of Premium Benefit Rider

AGREEMENT

I, the Proposed Insured, agree that:

1. All answers in this Application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability.
2. The first premium is equal to the full premium for the Premium Payment Mode selected. If the first premium is paid on the date this Application is signed, the insurance applied for becomes effective on that date subject to: a. the Company's underwriting requirements, b. the terms of the attached Conditional Receipt, and c. the terms of the policy applied for.
3. If the first premium is not paid on the date this Application is signed, no insurance will be in effect unless: a. such policy is issued, delivered to and accepted by me, and the entire first premium is paid during my lifetime, and b. at the time of such delivery, acceptance or payment, whichever is later, all information furnished in this Application remains true and complete to the best of my knowledge.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau Inc., that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. A photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for two years from the date shown below. I understand that I or my authorized representative may receive a copy of this authorization.

Signed at _____ on __/__/____ by _____
City *State* *Date (MM/DD/YYYY)* *Signature of Proposed Insured*

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions regarding the Proposed Insured:

1. a. What amount was collected with this application? $ _____

   b. Has a Conditional Receipt been given to the Proposed Insured? ☐ Yes ☐ No

   c. Has a Fair Credit and MIB Notification been given to the Proposed Insured? ☐ Yes ☐ No

2. a. Did you personally see the Proposed Insured on the date of application? ☐ Yes ☐ No

   b. How well do you know the Proposed Insured? ☐ Well ☐ Slightly ☐ Not at all

   c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect their insurability? ☐ Yes ☐ No

   If YES, please provide details: _____

   d. Is the Proposed Insured a citizen of the United States? If NO, provide a copy of a permanent visa—front and back. ☐ Yes ☐ No

3. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
   If YES, please complete and return the appropriate State Replacement Form.

4. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ % Agent No. _____ %

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____	/ /	( ) / ( )
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*

LIST BILL

☐ Set up NEW list bill *(Complete Employer's Authorization and Case Agreement)*. ☐ Add to existing list bill; indicate list bill no. _____

Name of Company _____

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

Type of Account: ☐ Checking ☐ Savings ☐ Add to existing bank withdrawal; indicate other applicant or policy numbers: _____

☐ NEW – Sign authorization below, attach voided check. Date of Withdrawal _____

***Date of Withdrawal cannot be* the 29th, 30th or 31st.** If no date is entered, the policy issue date will be used.

☐ **Initial premium only** ☐ **Recurring premiums only** ☐ **Initial and recurring premiums**

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account.

THIS PORTION HAS BEEN REPLACED WITH FORM 75-050-05055

_____	_____	_____
Name of Financial Institution	*Routing No. (9-digit number)*	*Account No.*
DO NOT SIGN _____	/ /	( )
Signature of Account Holder	*Date (MM/DD/YYYY)*	*Telephone No.*

CREDIT CARD AUTHORIZATION

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate charges to my credit card listed below for premiums as selected below. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any charges to my credit card.

☐ **Initial premium only** ☐ **Recurring premiums only** ☐ **Initial and recurring premiums**

THIS PORTION HAS BEEN REPLACED WITH FORM 75-050-05055

The Company's authority to charge the initial premium to your credit card for this insurance does not begin until the date the policy is issued. The premium will not be deemed paid and no coverage will be in force until payment is initiated.

Type of Card: ☐ MasterCard ☐ Visa ☐ Discover

Date of Charge: ☐ 1st ☐ 5th ☐ 10th ☐ 15th ☐ 20th ☐ 25th

IF NO DATE IS SELECTED, RECURRING CHARGES WILL OCCUR ON THE OPTION DATE IMMEDIATELY PRIOR TO THE POLICY ISSUE DATE.

_____	_____	_____
Name as it appears on card (Please print)	*Card/Account No.*	*Expiration Date (MM/YY)*
DO NOT SIGN _____	/ /	( )
Signature of Account Holder	*Date (MM/DD/YYYY)*	*Telephone No.*

AssurityBalance® Simplified Disability Income Insurance (DI)

Base Policy Sample Rates

Annual Premium per $100 Monthly Benefit

		6 mo./ 30-day				6 mo./ 60-day				6 mo./ 90-day				6 mo./ 180-day			
		Male		Female		Male		Female		Male		Female		Male		Female	
		Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	18-39	$11.38	$13.39	$17.06	$20.07	$8.54	$10.05	$12.80	$15.06	$3.26	$3.84	$4.89	$5.75	$2.87	$3.38	$4.30	$5.06
	40-49	17.72	20.85	24.81	29.19	14.01	16.48	19.62	23.08	7.13	8.39	9.99	11.75	6.27	7.38	8.79	10.34
	50+	26.30	30.94	28.93	34.04	22.10	26.00	24.31	28.60	14.30	16.82	15.73	18.51	12.58	14.80	13.84	16.28
Class 2	18-39	21.08	24.80	31.62	37.20	16.86	19.84	25.29	29.75	9.02	10.61	13.53	15.92	7.94	9.34	11.91	14.01
	40-49	30.68	36.09	38.35	45.12	25.05	29.47	31.32	36.85	14.60	17.18	18.25	21.47	12.85	15.12	16.06	18.89
	50+	44.20	52.00	46.41	54.60	37.55	44.18	39.43	46.39	25.20	29.65	26.46	31.13	22.18	26.09	23.28	27.39

		1 yr./ 30-day				1 yr./ 60-day				1 yr./ 90-day				1 yr./ 180-day			
		Male		Female		Male		Female		Male		Female		Male		Female	
		Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	18-39	16.61	19.54	24.92	29.32	13.03	15.33	19.54	22.99	6.37	7.49	9.56	11.25	5.61	6.60	8.41	9.89
	40-49	26.62	31.32	37.27	43.85	21.90	25.76	30.66	36.07	13.13	15.45	18.38	21.62	11.55	13.59	16.17	19.02
	50+	40.83	48.04	44.91	52.84	35.60	41.88	39.16	46.07	25.90	30.47	28.49	33.52	22.79	26.81	25.07	29.49
Class 2	18-39	30.14	35.46	45.21	53.19	25.02	29.44	37.53	44.15	15.51	18.25	23.27	27.38	13.65	16.06	20.48	24.09
	40-49	45.43	53.45	56.79	66.81	38.44	45.22	48.05	56.53	25.45	29.94	31.82	37.44	22.40	26.35	28.00	32.94
	50+	67.84	79.81	71.23	83.80	59.65	70.18	62.63	73.68	44.44	52.28	46.66	54.89	39.11	46.01	41.06	48.31

		2 yr./ 30-day				2 yr./ 60-day				2 yr./ 90-day				2 yr./ 180-day			
		Male		Female		Male		Female		Male		Female		Male		Female	
		Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	18-39	22.93	26.98	34.39	40.46	18.56	21.84	27.83	32.74	10.44	12.28	15.66	18.42	9.19	10.81	13.78	16.21
	40-49	39.02	45.91	54.63	64.27	33.08	38.92	46.32	54.49	22.06	25.95	30.88	36.33	19.41	22.84	27.17	31.96
	50+	62.63	73.68	68.89	81.05	56.13	66.04	61.74	72.64	44.06	51.84	48.46	57.01	38.77	45.61	42.64	50.16
Class 2	18-39	41.00	48.24	61.50	72.35	35.03	41.21	52.54	61.81	23.93	28.15	35.89	42.22	21.06	24.78	31.58	37.15
	40-49	65.95	77.59	82.44	96.99	57.42	67.55	71.78	84.45	41.59	48.93	51.99	61.16	36.60	43.06	45.75	53.82
	50+	103.28	121.51	108.45	127.59	93.22	109.67	97.88	115.15	74.53	87.68	78.26	92.07	65.59	77.16	68.87	81.02

Critical Illness Rider Rates

Annual Premium Rates per $5,000 Lump Sum Benefit				
	Non-Tob.		Tob.	
	Male	Female	Male	Female
18-39	$26.05	$29.88	50.51	45.91
40-49	65.74	62.01	123.83	96.27
50+	144.08	106.79	267.68	176.23

Return of Premium Rider Rates

Percentage of Total Annual Premium for Base Policy and All Other Riders				
Occ Class 1 & 2, All Benefit Periods				
Elim. Period	30	60	90	180
18-39	40%	47%	53%	59%
40-49	77%	89%	101%	113%
50+	157%	172%	188%	204%

See second page for Retroactive Injury Rider rates and a premium worksheet

This policy may contain reductions of benefits, limitations and exclusions. For costs and complete details of the coverage, please contact Assurity Life Insurance Company or ask to review the policy for more information.

Policy availability, rates and features may vary by state.

FOR PRODUCER USE ONLY.

Policy Form No. I D0710
Rider Form Nos. R I0711, R I0712, R I0713

Retroactive Injury Rider Rates

Annual Premium per $100 Monthly Benefit																
	6 mo./ 30-day				6 mo./ 60-day				6 mo./ 90-day				6 mo./ 180-day			
	Male		Female		Male		Female		Male		Female		Male		Female	
	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	$1.27	$1.49	$1.90	$2.24	$1.20	$1.41	$1.80	$2.12	$1.07	$1.26	$1.60	$1.88	$0.94	$1.11	$1.41	$1.66
Class 2	2.93	3.45	3.81	4.48	3.11	3.66	4.04	4.75	3.45	4.06	4.48	5.27	3.04	3.58	3.94	4.64

	1 yr./ 30-day				1 yr./ 60-day				1 yr./ 90-day				1 yr./ 180-day			
	Male		Female		Male		Female		Male		Female		Male		Female	
	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	1.23	1.45	1.85	2.18	1.16	1.36	1.75	2.06	1.04	1.22	1.56	1.84	0.92	1.08	1.37	1.61
Class 2	2.85	3.35	3.71	4.36	3.03	3.56	3.94	4.64	3.36	3.95	4.36	5.13	2.96	3.48	3.84	4.52

	2 yr./ 30-day				2 yr./ 60-day				2 yr./ 90-day				2 yr./ 180-day			
	Male		Female		Male		Female		Male		Female		Male		Female	
	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	1.20	1.41	1.80	2.12	1.13	1.33	1.70	2.00	1.01	1.19	1.52	1.79	0.89	1.05	1.34	1.58
Class 2	2.78	3.27	3.61	4.25	2.95	3.47	3.83	4.51	3.27	3.85	4.25	5.00	2.88	3.39	3.74	4.40

Sample Premium Calculation

Male, age 20 – Class 1 – Non-Tob. – $1,000 – 2 yr./ 30-day Benefit									
Base Benefit	$22.93 (Base Rate)	x	10 (# of 100s of Base)	=	$229.30	BASE PREMIUM			
	$229.30 (Base Premium)	+	$40 (Policy Fee)	=	$269.30	x	0.088 (Modal Factor*)	=	$23.70
Retroactive Injury Benefit Rider (RIB)	$1.20 (RIB Rate)	x	10 (# of 100s of Base)	=	$12	x	0.088 (Modal Factor*)	=	$1.06
Critical Illness Rider	$26.05 (CI Rate)	x	2 (# of 5000s)	=	$52.10	x	0.088 (Modal Factor*)	=	$4.58
SUBTOTAL	(Sum of all the premiums in the right-most column)							=	$29.34 SUBTOTAL PREMIUM
Return of Premium Rider	40% (Percent)	x	$29.34 (Subtotal Premium)					=	$11.74 ROP RIDER PREMIUM
Total Modal Premium	(Sum of Subtotal Premium and ROP Rider Premium)							=	$41.08

* Modal Factors: Annual = 1.000; Semi-annual = 0.510; Quarterly = 0.264; Monthly = 0.088

Your Premium Calculation

Male or Female – Age: ____ – Class 1 or 2 – Non-Tob. or Tob. – Amount:_____ – Benefit:_____									
Base Benefit	$ (Base Rate)	x	(# of 100s of Base)	=	$	BASE PREMIUM			
	$ (Base Premium)	+	$40 (Policy Fee)	=	$	x	(Modal Factor*)	=	$
Retroactive Injury Benefit Rider (RIB)	$ (RIB Rate)	x	(# of 100s of Base)	=	$	x	(Modal Factor*)	=	$
Critical Illness Rider	$ (CI Rate)	x	(# of 5000s)	=	$	x	(Modal Factor*)	=	$
SUBTOTAL	(Sum of all the premiums in the right-most column)							=	$ SUBTOTAL PREMIUM
Return of Premium Rider	% (Percent)	x	$ (Subtotal Premium)					=	$ ROP RIDER PREMIUM
Total Modal Premium	(Sum of Subtotal Premium and ROP Rider Premium)							=	$

FOR PRODUCER USE ONLY.

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
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.

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Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

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Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

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

Confidential Information Authorization for Release of Psychotherapy Notes

_____ / / _____
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.

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*

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

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

Confidential Information Authorization for Release of Psychotherapy Notes

_____ / / _____
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.

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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
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (888) 255-2060

CONSUMER NOTICE

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 all Health 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)* 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 liability under this Agreement is limited to:

- $2,500 of disability coverage or business overhead coverage;
- The amount of hospital indemnity coverage applied for; or
- $50,000 of critical illness coverage, including any other critical illness coverage applied for 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; or
- The application contains a material misrepresentation to Assurity.

Dated at _____ On _____
City, State *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)

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

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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
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Dated at _____ On _____
City, State *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)

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

Accident or Health Insurance
REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application *(information you have furnished)*, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Assurity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions that you may presently have *(pre-existing conditions)*, may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date (MM/DD/YYYY)	*Applicant's Signature and Printed Name*

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.

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

Accident or Health Insurance
REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

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1. Health conditions that you may presently have *(pre-existing conditions)*, may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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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.

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)

ASSURITY® LIFE INSURANCE COMPANY
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630
ASSURITY® LIFE INSURANCE COMPANY OF NEW YORK
(844) 401-7585 • FAX (877) 864-6630
Admin. Office: P.O. Box 82533, Lincoln, NE 68501-2533

NEW BUSINESS FAX TRANSMITTAL

PLEASE PRINT WITH BLACK INK

Use one cover sheet per application and fax to Assurity at (877) 864-6630

Date ____/____/____ *(MM/DD/YYYY)*

APPLICANT INFORMATION

Applicant Name _____

☐ New Application ☐ Outstanding Requirements Policy No. _____

DOCUMENTS ATTACHED

☐ Application ☐ Disclosures ☐ Replacement Forms
☐ Authorizations ☐ Exams/Labs ☐ 1035 Exchange Forms
☐ Check Authorization *(PAC)* ☐ Illustration ☐ Other _____
☐ Delivery Forms ☐ Income Documents ☐ Other _____

PRODUCT TYPE

☐ Life ☐ Disability ☐ Critical Illness ☐ Annuity ☐ Tele-app ☐ Drop Ticket

NOTES

AGENT INFORMATION

Agent Name (Print) _____ Agent No. _____

Phone No. (____) _____ Fax No (____) _____ E-mail Address _____