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.

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

Application for INSURANCE

PLEASE PRINT IN BLUE OR BLACK INK

1. PROPOSED INSURED

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

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

Street Address / City / State / ZIP+4
Home 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? ..... ☐ Yes ☐ No

If YES, please list type: amount per day: 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

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

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

Years Months

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

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 $

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

If Ownership is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

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

Social Security No.	Relationship to Insured	Birth State/Country
Home Address (Street Address / City / State / ZIP+4)		E-mail

Contingent Owner's Name (First / Middle / Last)	Contingent Owner's Relationship to Insured

3. BENEFICIARIES *(Do not complete if applying for Reversionary Annuity coverage)*

If Beneficiary is a trust, or if additional space is needed, complete the Trust Information/Additional Beneficiary form.

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

4. PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below:

Type

☐ Direct Billing ☐ ~~Automatic Credit Card~~
☐ List Billing *(employer)* ☐ Automatic Bank Withdrawal

Frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ Monthly *(not available with Direct Billing)*

Payor Name (First / Middle / Last)	Billing Address (Street Address / City / State / ZIP+4)
Secondary Payor Info. (First / Middle / Last)	Billing Address (Street Address / City / State / ZIP+4)

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 | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Address of Trustee(s) *Street Address* *City* *State* *ZIP+4*

2. BENEFICIARIES

☐ Testamentary Trust *(Will)* Share % _____

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

Name of Living Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Street Address *City* *State* *ZIP+4*

Address of Trustee(s)

3. ADDITIONAL BENEFICIARIES *(Do not complete if applying for Reversionary Annuity)*

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

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? ☐ 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 contemplating flying as a pilot, crew member or student? ☐ Yes ☐ No

   b. Has any Proposed Insured participated in, or contemplated participation 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

3. During the next **12 months**, does any Proposed Insured contemplate residence 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 reason for change:

   _____

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 had more than 3 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. a. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

   If YES, provide details below. If any Proposed Insured is applying for life coverage, complete and return the appropriate State Replacement Form.

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

Insured's Name	Company Name	Policy No.	Individual (I) Group (G)	Benefits *(monthly benefit and benefit period for DI or face amount for Life)*	Issue Date *(MM/DD/YYYY)*	DI Coverage Only: Coordinates w/ Soc. Sec.?	DI Coverage Only: Employer Paid?
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No

10. **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 2.

1. Has any Proposed Insured **ever** 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's 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, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder *(lupus or scleroderma)*? ☐ Yes ☐ No

   f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? ☐ Yes ☐ No

   g. Arthritis, rheumatism 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

   j. Any other illness or injury requiring medical attention or blood transfusions? ☐ Yes ☐ No

2. 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. 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 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

   e. 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

3. Has any 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 any Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes 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** had 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)* ____/____/____

DETAILS: Enter complete details from questions #1-5 on page 2. 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:

Home Office Use Only

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.

☐ Disability Waiver of Premium Benefit Rider

☐ Monthly Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Critical Illness Benefit Rider for Primary Insured $ _____

☐ Children's Term Insurance Rider *(complete next page)* _____ units

☐ Other Insured Term Insurance Benefit Rider *(complete next page)* $ _____

☐ Monthly Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Critical Illness Benefit Rider- Other Insured *(complete next page)* $ _____

☐ Return of Premium 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.

☐ Disability Waiver of Premium Benefit Rider

☐ Monthly Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Critical Illness Benefit Rider for Primary Insured $ _____

☐ Children's Term Insurance Rider *(complete next page)* _____ units

☐ Protected Insurability Benefit Rider $ _____

☐ Monthly Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Critical Illness Benefit Rider- Other Insured *(complete next page)* $ _____

☐ Accidental Death Benefit Rider $ _____

☐ Level Term Insurance Benefit Rider for Primary Insured *(Select only one)*: ☐ 10-Year ☐ 20-Year $ _____

☐ Level Term Insurance Benefit Rider — Other Insured *(Select only one)*: ☐ 10-Year ☐ 20-Year $ _____

☐ Payor Benefit Rider *(Complete Health Section for Payor)* Payor Name _____ DOB ___/___/___ ☐ M ☐ F

☐ Paid-Up Additions Rider *(VER)* ☐ Periodic Premiums $ _____ ☐ Single Premium $ _____

SINGLE PREMIUM WHOLE LIFE INSURANCE

Face Amount $ _____

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	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to Proposed Insured				
Employer				
Occupation/Duties				
Gross monthly income	$			
If self-employed, net monthly income	$			

Has any proposed insured child:

a. Ever been diagnosed with or treated for internal cancer or tumor, lymphoma, leukemia, disorder of the lymph nodes or glandular disorder? ..... ☐ Yes ☐ No

b. Ever been diagnosed with or treated for heart disease or disorder? ..... ☐ Yes ☐ No

c. Had any diagnostic tests recommended but not completed or for which the results are currently unknown or pending? ..... ☐ Yes ☐ No

If YES to any of the above, please list child(ren)'s name(s): _____

Has the Other Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No *(Not applicable to Child Riders.)*

If YES, please list type: amount per day: 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.

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 seen 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 seen:

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 continued good health and the life and continued good health of any other person(s) covered under the policy. 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.

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 shall also be subject to a substantial civil penalty where and to the extent allowed by 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 _____ on ___/___/___
City *State* *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 Beneficiary (If applying for Reversionary Annuity)*

_____ _____
Signature of Licensed Agent *Print Agent Name and Agent No.*

FIELD UNDERWRITER'S STATEMENT

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

   b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ☐ No

   c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ☐ Yes ☐ No

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

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

   c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? If YES, please provide details below. ☐ Yes ☐ No

   _____

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ☐ Yes ☐ No

   Agent is responsible for scheduling exam items.

   NOTE: ANY PREFERRED PLANS REQURE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.

   ☐ Paramedical examination ☐ Blood Sample ☐ Urine Sample ☐ Electrocardiogram *(EKG)* ☐ Treadmill EKG ☐ Medical exam by physician

4. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

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

6. Was sales material used in soliciting this application? ☐ Yes ☐ No

7. Was the sales material left with the applicant? ☐ Yes ☐ No

8. Was the sales material approved by Assurity Life Insurance Company? ☐ Yes ☐ No

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

AUTOMATIC PAYMENT OPTIONS

☐ 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.~~

LIST BILL

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

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

FOR TERM LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:

$350,000 and under: ☐ Select + NT ☐ Select NT ☐ Standard NT ☐ Select + T ☐ Select T ☐ Standard T

$350,001 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Standard NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

FOR WHOLE LIFE APPLICATION *(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)*

The premiums for this application were quoted on the following underwriting classification:

$99,999 and under: ☐ Select NT ☐ Standard T

$100,000 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

FOR UNIVERSAL LIFE APPLICATION *(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)*

The premiums for this application were quoted on the following underwriting classification:

☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Additional Insured's underwriting classification _____

FOR REVERSIONARY ANNUITY APPLICATION *(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)*

The premiums for this application were quoted on the following underwriting classification: ☐ Preferred NT ☐ Standard NT ☐ Tobacco

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*

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

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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.

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

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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.

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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 • 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 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 _____ 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
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Temporary Conditional Insurance Agreement

(for use with Life and Reversionary Annuity products)

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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
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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.

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- 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 _____ 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)

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DISCLOSURE STATEMENT

MODIFIED ENDOWMENT CONTRACT

The Technical and Miscellaneous Revenue Act of 1988 created a new type of life insurance contract known as a Modified Endowment Contract *(MEC)*. The 1988 law discourages the use of life insurance as an investment by giving less favorable tax treatment to policies classified as MECs. As indicated later in this disclosure, attempts by the owner to access tax-deferred cash values from a MEC *(directly or indirectly)* before the insured's death are taxed adversely *(compared to a non-MEC policy)*.

Section 7702A of the Internal Revenue Code classifies a policy as a MEC if premiums paid into the policy exceed a certain limit in relation to the policy's death benefit *(including any qualified additional benefits, such as a term rider)*. Premium payments are measured over a timeframe known as the "7-pay test period," and if cumulative premiums during any 7-pay test period exceed the 7-pay limit specified in Section 7702A, the policy is a MEC. A 7-pay test period normally starts on the policy's issue date and ends seven years after the issue date, unless there is a restart of the 7-pay test period due to a material change. Material changes that might generate a restart of the 7-pay test period include a requested increase in the death benefit or an addition of a qualified additional benefit under the contract. Any reduction in a qualified benefit level during any 7-pay test period will generally require the policy's 7-pay limit to be reduced retroactively to the start of that 7-pay test period *(as if this reduced benefit level started when this 7-pay test period began)*. The lower 7-pay limit can cause the policy to become a MEC.

Once a policy becomes a MEC, any amount received or deemed to be received from the policy *(other than a death benefit)* is subject to the following adverse U.S. income tax treatment.

1) An amount distributed directly or indirectly from a MEC, such as cash distributions, withdrawals, loans, assignments, ownership changes or pledges will be considered taxable income until all gain, if any, has been distributed. A distribution made within two years prior to the failure of the 7-pay test will be considered a distribution made in anticipation of such a failure.
2) The taxable income amounts will be subject to a 10 percent penalty tax unless the owner is an individual who has attained age $59^1/_2$, is disabled, or annuitizes the entire cash value. *(If the owner is a corporation, trust or other entity, such proceeds are subject to the 10 percent penalty tax at any time.)*

This adverse tax treatment is expanded by certain deemed tax treatment rules, which are designed to prevent an owner from avoiding adverse MEC treatment by attempting to gain access to the cash values via alternative methods before death. For instance, all MECs purchased by the same owner during the same calendar year from the same insurer are treated as one MEC. Therefore, any amount received or deemed received from any one of those MECs would be considered taxable income until all gain, if any, has been distributed from all of those MECs combined.

Death benefits from a MEC paid to the beneficiary after the insured's death are still treated as life insurance proceeds and are generally not subject to U.S. income tax.

Assurity does not give tax advice, and this disclosure should not be interpreted as tax advice. Rather, this disclosure is intended to alert you to the potential scope of the adverse U.S. tax treatment of any amounts received or deemed received from a MEC prior to death of the insured. Please consult with a qualified tax advisor if you have questions.

I acknowledge that I have read this disclosure statement and that I understand my plan of insurance with Assurity is a Modified Endowment Contract and therefore subject to special U.S. tax treatment as outlined above.

/ /		
Date (MM/DD/YYYY)	*Signature of Owner/Proposed Owner*	*Printed Name*
Print Insured/Proposed Insured's Name (First, Middle, Last)		*Policy Number (if applicable)*

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INFORMED CONSENT FOR HIV TESTING

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

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other body fluid sample for testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health or disability insurance for which you may apply in the future.

THE HIV VIRUS

The HIV virus causes a life-threatening disorder of the immune system called acquired immune deficiency syndrome *(AIDS)*. Antibodies to the HIV virus are found in the blood of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood *(as in needle sharing during intravenous drug use, or rarely, as a result of a blood transfusion)*, or from an infected mother to her newborn infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

PRE-TESTING CONSIDERATION

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

DISCLOSURE OF TEST RESULTS

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test is normal, you will not be notified. You will be notified of an abnormal *(positive)* test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood abnormality may be made known to the Medical Information Bureau, Inc. *(MIB)*. The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record that you have some blood abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

TEST RESULTS

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medication. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your professional health care provider.

HIV test results are highly reliable but not 100 percent accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

OTHER SOURCES OF INFORMATION

For more information about AIDS, you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS *(2437)*. The hotline is a free call.

CONSENT FOR HIV TESTING

I have read and understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood, or to the providing of another bodily fluid sample, the testing my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This CONSENT is valid for ninety *(90)* days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this ninety *(90)* day period.

NOTIFICATION OF POSITIVE TEST RESULT

In the event of a positive HIV test result:

☐ Send the result to me at:

_____

Address

☐ I authorize Assurity Life Insurance Company *(ALIC)* to send the result to another person:

_____

Name

_____

Address

☐ I authorize ALIC to send the result to the following physician or health care provider:

_____

Name

_____

Address

AUTHORIZATION

_____

Printed Name of Proposed Insured

_____ _____

Signature of Proposed Insured or Parent/Guardian *Date (MM/DD/YYYY)*

_____ _____

Signature of Person Obtaining Consent *Date (MM/DD/YYYY)*

ASSURITY® LIFE INSURANCE COMPANY
1526 K Street, P.O. Box 82533, Lincoln, NE 68501
402.476.6500 • 800.276.7619 • FAX 402.437.4591

Life Insurance or Annuity
REPLACEMENT NOTICE

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

If you answered "Yes" to either of the above questions, list each existing policy or contract 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 will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent 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 agent 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:

_____ _____
Applicant's Signature and Printed Name *Date*

_____ _____
Producer's Signature and Printed Name *Date*

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 agent 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 agent 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 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?

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.

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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.

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INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent 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 agent 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:

_____ _____
Applicant's Signature and Printed Name *Date*

_____ _____
Producer's Signature and Printed Name *Date*

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.

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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 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?

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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?

Signed form to be returned to the home office.
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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

Illustration Disclosure Statement

Name of Proposed Insured _____
First *Middle* *Last*

Name of Agent preparing disclosure _____
First *Middle* *Last*

Proposed Insured's acknowledgement and Agent's certification that:

☐ Application differs from illustration

☐ No illustration used in sales process

☐ Illustrations provided on computer screen. If a computer screen illustration was used, it was based on the following:

Gender: ☐ Male ☐ Female

Age _____

Product Name and Form No. _____

Premium Amount _____

Riders and Form No. _____

Guaranteed Interest Rate _____

Underwriting Class _____

Non-Guaranteed Interest Rate _____

Dividend Option _____

No. of Policy Years Illustrated _____

Initial Death Benefit _____

Assumed No. of Years of Premium _____

PROPOSED INSURED ACKNOWLEDGMENT

I acknowledge that I did not receive an illustration matching my application for insurance for the reason marked above. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

_____ _____
Date (MM/DD/YYYY) *Proposed Insured's Signature*

AGENT CERTIFICATION

I certify that:

a. An illustration matching the application for insurance was not provided at time of sale for the reason marked above.
b. I explained that a conforming illustration would be produced and delivered no later than at the time of policy delivery.
c. I have made no statements that are inconsistent with the illustration that will be produced.

_____ _____
Date (MM/DD/YYYY) *Agent's Signature*

Any Proposed Insured residing in MA, ME, PA, SD or WA must retain a copy of this completed form.

ASSURITY® LIFE INSURANCE COMPANY
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ACCELERATED BENEFITS RIDER DISCLOSURE STATEMENT

For use with: Universal Life and Single-Premium Whole Life

BENEFITS PAID UNDER THE RIDER MAY BE TAXABLE. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS.

The rider provides an accelerated payment of life insurance proceeds under conditions specified in the rider. It is not intended to provide health, nursing home or long-term care insurance. Payment of the rider benefit will reduce the amount of life insurance in force under the policy. Benefit payments may affect qualifications for entitlement payments.

DEFINITIONS

Home Care means a written program of medically necessary care ordered by a Physician and provided, for pay, by a licensed health care provider who is not a member of the insured's immediate family.

Long-Term Care Facility means a place which:

- is licensed to provide skilled or intermediate nursing care for sick and injured persons, at the insured's expense;
- operates under the supervision of a Physician or a registered nurse;
- has 24-hour nursing service by or under the supervision of a registered nurse or a licensed practical nurse; and
- has beds for patients who need nursing care.

Note: A Long-Term Care Facility does not mean: a hospital; a place that primarily treats the mentally ill, drug addicts or alcoholics; or a place owned or operated by a member of the insured's immediate family.

Net Amount of Insurance means the policy death benefit less the surrender value. This amount is based on the policy values *(excluding riders)* as of the first day an advance is paid. We will calculate the amount only once unless advances stop for 12 months or more.

Physician means a medical doctor *(M.D.)* or a doctor of osteopathy *(D.O.)*, licensed in the United States and operating within the scope of his or her license. Physician does not include the insured or a member of the insured's immediate family.

Terminal Illness means the insured has a life expectancy of 12 months or less as certified by a Physician.

ACCELERATED DEATH BENEFIT OPTIONS

Only one option may be elected.

Terminal Illness Option. If the insured has a Terminal Illness, the owner can ask us to advance up to 75 percent of the Net Amount of Insurance. The advance(s) may be made in a lump sum or in any way we agree.

Long-Term Care Facility, Home Care Option. If an insured age 65 or over has a disease or medical condition which requires continuous confinement in a Long-Term Care Facility or under a written plan of Home Care, and is expected to remain confined for the rest of his or her life, the owner can ask us for an advance. We can make an advance under this option by:

- A lump-sum payment of 50 percent of the Net Amount of Insurance; or
- 36 monthly payments of 2 percent of the Net Amount of Insurance determined on the day of the first payment.

We will only make an advance under this option after the insured has been confined or receiving Home Care continuously for three months. The confinement or Home Care must be medically necessary and ordered by a Physician. The Home Care must be in lieu of confinement in a Long-Term Care Facility. If the confinement or Home Care stops, we will stop the monthly advances. If the confinement or Home Care starts again within 12 months, monthly payments can resume at the owner's request.

ADVANCE LIMITS

The maximum we will pay for all advances is $250,000. We will make no advance if the owner is required to use this benefit to pay:

- creditors;
- a governmental agency in order to receive or keep governmental benefits or entitlements; or
- for Home Care or confinement in a Long-Term Care Facility outside the United States of America.

INTEREST ON ADVANCES

We will charge interest on all advances. The interest rate will be the same as the current interest rate on policy loans. Interest on each advance starts when the advance is made. It may be paid at any time. Interest will be compounded on an annual basis to the date of death.

EFFECT ON POLICY

Payment of a benefit under the rider will not affect the policy's surrender value, premiums or any policy loan balance. Upon the insured's death, the balance of the death benefit, if any, will be payable to the beneficiary.

The following is added to the death benefit provision:

We will subtract:

- the amount of all advances paid; and
- unpaid interest on those advances.

Accelerated Benefit payments may adversely affect your eligibility for Medicaid or other government benefits or entitlements.

Your signature and the agent's signature below indicate that you received this **DISCLOSURE STATEMENT** at or before the time you applied for coverage.

Signature of Proposed Insured	*Printed Name of Proposed Insured*	/ / *Date (MM/DD/YYYY)*
Signature of Agent	*Printed Name of Agent*	/ / *Date (MM/DD/YYYY)*

ASSURITY® LIFE INSURANCE COMPANY
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ACCELERATED BENEFITS RIDER DISCLOSURE STATEMENT

For use with: Universal Life and Single-Premium Whole Life

BENEFITS PAID UNDER THE RIDER MAY BE TAXABLE. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS.

The rider provides an accelerated payment of life insurance proceeds under conditions specified in the rider. It is not intended to provide health, nursing home or long-term care insurance. Payment of the rider benefit will reduce the amount of life insurance in force under the policy. Benefit payments may affect qualifications for entitlement payments.

DEFINITIONS

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Your signature and the agent's signature below indicate that you received this **DISCLOSURE STATEMENT** at or before the time you applied for coverage.

Signature of Proposed Insured	*Printed Name of Proposed Insured*	/ / *Date (MM/DD/YYYY)*
Signature of Agent	*Printed Name of Agent*	/ / *Date (MM/DD/YYYY)*

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Customer Identification INFORMATION

PLEASE PRINT WITH BLACK INK

ANTI-MONEY LAUNDERING PROGRAM REQUIRES THE AGENT TO COMPLETE THIS FORM, PROVIDING THE FOLLOWING INFORMATION:

Legal name of Policyowner _____ Social Security number _____

Policyowner's occupation _____

1. Source of funds

- ☐ Current income
- ☐ 401k/Pension
- ☐ CD/Savings/Checking
- ☐ Mutual funds/Stocks
- ☐ Another person *(if so, provide name and relationship below)*

_____

- ☐ Inheritance
- ☐ Proceeds of canceled life insurance policy
- ☐ Annuity
- ☐ From values of existing life insurance policy
- ☐ Death benefit proceeds
- ☐ Other _____

2. Is the source of funds a variable life insurance or annuity contract? ☐ Yes ☐ No

If YES, are you licensed to sell variable contracts? ☐ Yes ☐ No

3. Intended purpose of coverage applied for

- ☐ Burial/final expenses
- ☐ Retirement
- ☐ Mortgage pay-off
- ☐ Funding a charitable contribution
- ☐ Periodic income
- ☐ Post-death family needs
- ☐ Educational expenses
- ☐ Business need *(e.g. key-person life insurance)*
- ☐ Other _____

4. Is this application the result of a lead? ☐ Yes ☐ No

If NO, please provide the information below in questions 5 and 6. If YES, proceed to question number 7.

5. Agent/Policyowner relationship

Length of time known *(in years)* _____ How known? _____

6. Provide any additional information you possess regarding the background of your relationship with the Policyowner

_____

_____

7. The information on this form was obtained from

Name _____

☐ Policyowner ☐ Applicant ☐ Payor ☐ Other *(specify)* _____

I certify all of the above information is true and correct to the extent of my knowledge and reflects the information provided to me by the individual named above, except where information from me is required.

_____	_____
Producer Signature	*Producer No.*
_____	___/___/___
Producer Name (printed)	*Date (MM/DD/YYYY)*

Mail or fax *(877-864-6630)* this completed and signed form along with the application submitted to the home office.

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*

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

The company's authority to debit from your account the first premium for this insurance does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Day of 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.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account listed below for all premiums. I understand that initiating automatic payments may result in additional drafts to bring my account current. 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. I further understand that if the date of the withdrawal is after the policy issue date and the premium is not honored, my policy may lapse and require evidence of insurability for reinstatement.

☐ Do not draft initial premium: ☐ 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
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 869-0355 • FAX (877) 864-6630

Life/Annuity TRANSFER/1035 EXCHANGE FORM

A. INSTRUCTIONS

1. Owner's signature and date of completion are required on this form.
2. For transfers or 1035 exchanges from annuities or life products, a replacement form must be completed if required by state.
3. Use a separate form for each company. Please print in black ink.

B. COMPANY INFORMATION

_____ ( ) _____
Current Trustee/Custodian/Insurance Company *Telephone No.*

_____
Company Address *City* *State* *ZIP+4*

_____ _____
Contract/Policy/Account No. *Investment Vehicle (CD, Mutual Fund, Life Insurance, Annuity)*

_____ _____ _____ _____
Insured/Annuitant's Full Name *Social Sec. or Tax I.D. No.* *Joint Insured/Annuitant's Full Name* *Social Sec. or Tax I.D. No.*

_____ _____ _____ _____
Policyowner/Account Owner's Full Name (if different from Insured or Annuitant) *Social Sec. or Tax I.D. No.* *Joint Owner's Full Name (if applicable)* *Social Sec. or Tax I.D. No.*

C. POLICY INFORMATION

The contract is: ☐ ENCLOSED ☐ NOT ENCLOSED *(partial exchange only)*

☐ LOST/DESTROYED—I certify that the policy is lost or destroyed. I also certify that the policy has not been assigned or pledged as collateral.

D. TYPE OF TRANSACTION

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS

☐ 1. **1035 EXCHANGE** from a nonqualified annuity or life insurance policy(ies) *(including IRS Section 457 Deferred Compensation)*.

A surrender of a life insurance policy to a non-qualified annuity, or a non-qualified annuity to another non-qualified annuity, qualifies as a 1035 exchange. A surrender of any type of annuity to a life insurance policy does NOT qualify as a 1035 exchange—any gain on your existing annuity will be subject to income tax. Exchanges into existing contracts should be approached cautiously, and only after consultation with a tax advisor, since the IRS has not yet issued definitive guidance regarding the permissibility of such exchanges.

I hereby make a partial or absolute assignment *(endorsement for contracts that are not assignable)* and understand that an absolute assignment transfers all rights, title and interest of every nature and character in and to the above policy to the insurance company indicated above in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. I represent that the above policy is not subject to any pledge, assignment, levy or legal proceeding. Upon receipt, the insurance company is directed to surrender all or part of the policy and apply the value to an annuity or life insurance policy for which I have submitted an application.

I understand that by executing this assignment, I irrevocably waive all rights, claims and demands under the above policy. I am aware of all penalties which may apply.

I acknowledge that the insurer is furnishing this form and participating in this transaction as an accommodation to me, and the indicated insurer assumes no responsibility or liability for my tax treatment under Section 1035 of the Internal Revenue Code or otherwise.

NOTICE REGARDING PARTIAL 1035 EXCHANGES TO EXISTING CONTRACTS: Partial exchanges with subsequent withdrawals or annuitizations may be subject to IRS challenge if entered into for the purpose of avoiding premature withdrawal or other penalties. In addition, the Internal Revenue Service has not issued guidelines regarding the apportionment of basis between contracts involved in partial exchanges. Until such guidance is issued, Assurity will utilize a pro-rata formula for such apportionment. While Assurity believes this will be consistent with any IRS guidelines ultimately issued, these guidelines could mandate a different allocation method.

☐ COMPLETE—Surrender/Liquidate all assets in my account totaling $ _____

☐ PARTIAL—Surrender/Liquidate assets totaling $ _____

Send the proceeds to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533:

☐ IMMEDIATELY—I am aware of all penalties which may apply.

☐ UPON MATURITY—Maturity date ___/___/_____ *(MM/DD/YYYY)*

Is this a 1035 exchange to an existing account? ☐ YES ☐ NO **If YES, provide policy no.** _____

D. TYPE OF TRANSACTION *(continued)*

☐ 2. **TRANSFER QUALIFIED RETIREMENT ACCOUNT(S) (CURRENT PLAN TYPE)**

☐ ROTH IRA ☐ Simple IRA ☐ Traditional IRA ☐ SEP IRA
☐ KEOGH ☐ 401*(k)* ☐ Qualified Retirement Plan

☐ COMPLETE—Surrender/Liquidate all assets in my account totaling $ _____

☐ PARTIAL—Surrender/Liquidate assets totaling $ _____

Send the proceeds to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533:

☐ IMMEDIATELY—I am aware of all penalties which may apply.

☐ UPON MATURITY—Maturity date ____/____/____ *(MM/DD/YYYY)*

Is this a transfer to an existing account? ☐ YES ☐ NO **If YES, provide policy no.** _____

E. SIGNATURES

Under penalty of perjury, I certify that the foregoing information is true, correct and complete.

____/____/____	_____	_____
Date (MM/DD/YYYY)	*Signature of Contract Owner*	*Printed Name*
____/____/____	_____	_____
Date (MM/DD/YYYY)	*Signature of Joint Owner (if applicable)*	*Printed Name*

SIGNATURE GUARANTEE *(if required by the prior carrier)*	**ASSURITY LIFE INSURANCE COMPANY** By _____ Title _____