Apply for your policy in three easy steps…

Congratulations on your decision to protect your financial future with insurance from Assurity Life Insurance Company. Assurity has a legacy of helping people through difficult times for generations and providing "best in class" service to our policyholders.

Thank you for completing the initial insurance paperwork with your agent. **You will make no premium payment at this time.**

Step 1: Telephone Interview

You will be contacted by phone to schedule a time to provide your medical history to an experienced telephone interviewer. We will work with your schedule so that your interview (approximately 20-30 minutes) is private and convenient for you. The information will be kept strictly confidential and used only for this application.

We strongly recommend that you gather the following information so the interview will go quickly. Please be prepared to provide:

- ✔ *Medical information, including physicians' contact information; hospitalizations, office visits and treatments; and prescription drug history over the last two years. Also be prepared to give the drug name, dosage and frequency.*
- ✔ *Company names, insurance types and coverage amounts of your other life or health insurance policies.*
- ✔ *Specific financial information (completed tax returns for the last two years).*

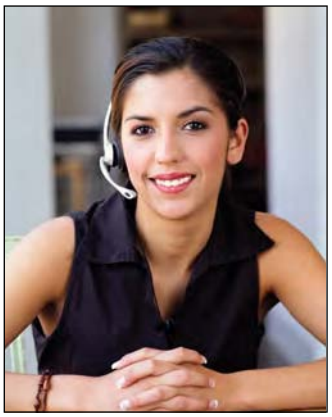
Depending on the type of insurance for which you are applying, you may also need to provide the following:

- ✔ *Medical history for your parents and siblings*
- ✔ *Driving history*
- ✔ *Leisure activities*

Insurance protection is an important component in securing your financial future. Thank you for choosing Assurity for your insurance needs.

Step 2: Schedule Exam

During the phone interview, your interviewer may need to schedule a mini-medical exam, which may include providing blood and/or urine samples, at your convenience. A licensed professional can provide a short exam at home or work, or you may visit one of our affiliated medical facilities.



Step 3: Policy Approval & Delivery

Once Assurity has reviewed your information, your agent will inform you of the status of your paperwork. If your request is approved, your agent will deliver your policy to you, along with the completed application for you to review and sign. **The premium and/or an automatic bank withdrawal form will be collected at this time.**

Please feel free to call us at (877) 611-4701 if you haven't received a phone call from our interview unit within five business days of completing your paperwork.

Interview hours are:
Monday through Thursday: 7 am–9 pm (Central)
Friday: 7 am–6 pm (Central)
Saturday: 9 am–1 pm (Central)

NOTE: Coverage cannot be bound.
Do not send payment with application.

Assurity®
Life Insurance Company
PO Box 82533 • Lincoln, NE 68501-2533
www.assurity.com

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TeleApp REQUEST FORM

PLEASE PRINT IN BLUE OR BLACK INK

To **Assurity Life Insurance Company** FAX **(877) 864-6630** Application State _____

Agent _____ Agent ID No. _____ Agent Phone No. ( )

PROPOSED INSURED

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

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

Home Address (Street Address, City, State, ZIP+4) | Birth State/Country

Residence Phone No. ( ) | Cell Phone No. ( ) | Business Phone No. ( )

Driver's License No./State | 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.

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

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

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

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

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

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

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

BENEFICIARIES

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 %**
			/ /	
			/ /	

PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below:

Type

☐ Direct Billing ☐ Automatic Bank Withdrawal
☐ List Billing *(employer)*

Frequency

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

GENERAL SECTION

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

   If YES, please explain: _____

2. a. Is other insurance coverage in force for any Proposed Insured? ..... ☐ Yes ☐ No
   b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ..... ☐ Yes ☐ No

   If either a or b is answered YES, complete and return the appropriate State Replacement Forms *(if applicable)*.

LIFE PRODUCT SECTION

Additional benefits for term, whole life and universal life insurance may vary by state.

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)* $ _____

☐ Endowment Benefit Rider

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 and Occupation/Duties				
Gross monthly income	$			
If self-employed, net monthly income	$			

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

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. _____

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

AGENT STATEMENT

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

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

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

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

   c. Did the Proposed Insured approach you to purchase insurance? If YES, list their stated need for the insurance _____ ☐ Yes ☐ No

   d. Did the Proposed Insured(s) directly respond to you regarding each application question? ☐ Yes ☐ No

   e. Was a government-issued picture ID requested and reviewed for the Proposed Insured, Owner and Payor? ☐ Yes ☐ No

   f. Was each Proposed Insured present, and did you witness their signatures at the time the application was taken? ☐ Yes ☐ No

   g. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured(s)? If YES, please provide details below. ☐ 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 REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.

   ☐ Paramedical examination ☐ Blood sample ☐ Urine sample ☐ Electrocardiogram *(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 Name _____ Agent's No. _____ _____ %

   Agent Name _____ Agent's 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 employer authorization form 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:

☐ Preferred Plus 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:

☐ Preferred Plus 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 Plus NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification: _____

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
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Confidential Information Authorization

_____ / / _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

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

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

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

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

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

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

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

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Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

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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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_____ / / _____
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)

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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.

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)

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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***

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- Psychotherapy notes

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

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

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

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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

CONSENT FOR TESTING

WRITTEN CONSENT FOR HIV ANTIBODY TESTING

(Conventional Testing—Not for Use with a Rapid HIV Test)

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

Test Subject or No. _____ Date *(MM/DD/YYYY)* _____ Time _____ (AM) (PM)

I hereby grant my permission for a test to detect whether I have antibodies to HIV *(Human Immunodeficiency Virus)* in my body.

HIV testing is voluntary and requires your consent in writing. The purpose of HIV antibody testing is to show whether you are infected with HIV, the virus that causes AIDS *(Acquired Immune Deficiency Syndrome)*.

Any test result that indicates that antibodies for HIV are present is considered positive for HIV infection.

Before you consent to be tested for HIV, your healthcare provider should speak to you about:

- How HIV is passed from person to person and mother to baby;
- Steps to take that may prevent the transmission of HIV; and
- The meaning of an HIV antibody test result.

If you agree with the following statements and want to consent to HIV testing, please sign this form.

I have been counseled about the benefits of having an HIV test and understand that:

- Human immunodeficiency virus *(HIV)* is the virus that causes AIDS;
- HIV is spread by sexual intercourse, so all sexually active persons are potentially at risk for HIV infection;
- HIV is spread by sharing needles with another person during injection of drugs, so all injection drug users are potentially at risk for HIV infection;
- HIV can be passed from a mother to her baby during pregnancy, at delivery and through breastfeeding; and
- HIV antibody test results are confidential, and the law protects me from discrimination.

I understand that a positive result does not mean I have AIDS, but indicates that I have HIV infection.

I understand that if my test results are positive, I will be offered HIV counseling.

I understand that test results may indicate that a person has HIV antibodies when the person does not have the antibodies *(a false positive result)* or the test may fail to detect that a person has antibodies to the virus when the person does in fact have these antibodies *(a false negative result)*.

If my HIV antibody test result is negative, no further testing will be done at this time. A negative HIV antibody test result most likely means that I am not infected with HIV, but it may not detect a recent infection.

If my HIV antibody test result is positive, this means that antibodies to the virus were detected and that I am HIV infected.

Confidentiality of HIV Information:

If you take the rapid HIV test, your test results are confidential. Under Illinois law, confidential HIV information can be given only to people to whom you allow it to be given by your written approval, to people who need to know your HIV status in order to provide medical care and services, including: an authorized agent or employee of a health facility or a healthcare provider if the health facility or provider is authorized to obtain test results; those who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive.

The law also allows your confirmed HIV test results to be released: to public health officials as required by law; for payment for care and treatment; to a temporary caretaker of children taken into protective custody by the Illinois Department of Children and Family Services; and to any other entity permitted by the AIDS Confidentiality Act.

I understand that my test results will be kept confidential to the extent provided by law. In addition, I understand that I may withdraw from the testing at any point in time prior to the completion of laboratory tests. I understand that my testing is voluntary.

I agree to be tested and I agree that I may be told my test results.

I agree that if the result of my HIV test is positive I may be referred to another healthcare provider for follow-up testing and care.

I have been advised about the purpose, potential uses, limitations and meaning of the test results; the voluntary nature of the test; the right to withdraw consent at any time prior to the completion of laboratory tests; and the confidentiality protections under the law.

The information presented above has been completely and clearly explained to me, and all of my questions have been answered. I hereby authorize my physician or facility to collect an oral or blood specimen and perform an HIV antibody test on that specimen.

_____ _____
Patient/Client Signature or Signature of Legally Authorized Representative *Date (MM/DD/YYYY)*

_____ _____
Facility/Provider Witness *Date (MM/DD/YYYY)*

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

Life Insurance or Annuity
REPLACEMENT NOTICE

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or insurance producer that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in *your* best interest.

We are required by law to notify your existing company that you may be replacing their policy.

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

_____ _____
Insurance Producer's Signature and Printed Name *Date (MM/DD/YYYY)*

LIST BELOW THE IDENTIFICATION OF POLICIES WHICH ARE INVOLVED IN THE REPLACEMENT TRANSACTION:

INSURER	CONTRACT NO.	NAME OF INSURED

To be completed if replacing another policy.
Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

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

Life Insurance or Annuity
REPLACEMENT NOTICE

NOTICE REGARDING PROPOSED REPLACEMENT OF LIFE INSURANCE POLICY OR ANNUITY

Name of Existing Insurer _____

Insurer's Address _____
Mailing Address *City* *State* *Zip Code*

To Whom It May Concern:

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity(ies) for an individual presently insured with your company.

Identification

Name of Insured _____
First *M.I.* *Last*

Insured's Address _____
Mailing Address *City* *State* *Zip Code*

Contract Number(s) _____ _____

_____ _____

_____ _____

_____ _____

This notice is given pursuant to 50 Ill. Adm. Code 917.70(c)

_____ _____
Insurance Producer's Signature and Printed Name *Date (MM/DD/YYYY)*

To be completed if replacing another policy
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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Post Office Box 82533, Lincoln, NE 68501-2533
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Life Insurance or Annuity
REPLACEMENT NOTICE

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or insurance producer that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in *your* best interest.

We are required by law to notify your existing company that you may be replacing their policy.

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

_____ _____
Insurance Producer's Signature and Printed Name *Date (MM/DD/YYYY)*

LIST BELOW THE IDENTIFICATION OF POLICIES WHICH ARE INVOLVED IN THE REPLACEMENT TRANSACTION:

INSURER	CONTRACT NO.	NAME OF INSURED

To be completed if replacing another policy.
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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Life Insurance or Annuity
REPLACEMENT NOTICE

NOTICE REGARDING PROPOSED REPLACEMENT OF LIFE INSURANCE POLICY OR ANNUITY

Name of Existing Insurer _____

Insurer's Address _____
Mailing Address *City* *State* *Zip Code*

To Whom It May Concern:

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity(ies) for an individual presently insured with your company.

Identification

Name of Insured _____
First *M.I.* *Last*

Insured's Address _____
Mailing Address *City* *State* *Zip Code*

Contract Number(s) _____ _____

_____ _____

_____ _____

_____ _____

This notice is given pursuant to 50 Ill. Adm. Code 917.70(c)

_____ _____
Insurance Producer's Signature and Printed Name *Date (MM/DD/YYYY)*

To be completed if replacing another policy
Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

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

Accelerated Death Benefits Rider DISCLOSURE STATEMENT

ACCELERATED DEATH BENEFITS PAID UNDER THIS RIDER WILL REDUCE THE POLICY'S DEATH BENEFIT, PREMIUMS AND POLICY VALUES, WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE CASH VALUE.

BENEFITS PAID UNDER THIS RIDER MAY BE TAXABLE AND ARE NOT INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS.

This rider provides an accelerated payment of life insurance proceeds under conditions specified in this rider. It is not intended to provide health, nursing home or long-term care insurance. Cash values, loan values, if any, and death benefits will be reduced if you receive an accelerated benefit. Benefit payments may adversely affect qualifications for Medicaid or other government benefits or entitlement payments.

DEFINITIONS

Accelerated Amount means the portion of the Eligible Proceeds You elect to accelerate.

Benefit Amount means the portion of the Eligible Proceeds You elect to receive, adjusted by the Discount Factor.

Discount Factor means a factor that is applied to the death benefit being accelerated on the Election Date, which accounts for:

- reduced life expectancy;
- insured person's age and gender *(unless this policy was issued on a gender neutral basis, in which case male rates will be assumed)*;
- expected future premiums;
- current dividends, if any;
- interest rate. The maximum interest rate used will be no more than the greater of a) the current yield on 90-day treasury bills or b) the current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages—Monthly Average Corporates published by Moody's Investor Service, Inc., or successor thereto, for the calendar month ending two months before the date an accelerated payment is requested; and
- a one-time processing charge not to exceed $250. We will inform You of the charge when You request this rider's benefit.

Election Date means the date We receive Your application for the Benefit Amount.

Eligible Proceeds means the lesser of $250,000 or the policy Face Amount in force plus any paid-up additions and less any Loan Balance.

Immediate Family means the spouse, father, mother, children or siblings of an Insured Person.

Nursing Home means an institution which is not primarily a residential facility and is either:

- a Medicare-approved skilled nursing facility;
- state-licensed as a skilled nursing or intermediate care facility; or
- meets all of the following:
  - is state-licensed as a Nursing Home;
  - primarily provides nursing care;
  - is supervised by a registered or licensed practical nurse;
  - keeps daily patient medical records; and
  - records and controls all medications it gives.

Permanent Confinement Condition means a medical condition that is expected to require continuous permanent confinement in a Nursing Home for the remainder of an Insured Person's lifetime. Such a condition must be certified by a Physician.

Physician means a doctor of medicine or osteopathy who is duly licensed and practicing medicine in the United States and who is legally qualified to diagnose and treat sickness and injuries. Such Physician cannot be a member of an Insured Person's Immediate Family or business associate, and must be providing services within the scope of his or her license/specialty. Practitioners other than those named above are not Physicians.

Terminal Illness means a condition that results in an expected life span of 12 months or less. Such a condition must be certified by a Physician.

RIDER BENEFIT

Payment of Accelerated Benefits. If an Insured Person qualifies for the Terminal Illness Option or the Permanent Confinement Option, We will pay You the Benefit Amount. Payment will be made immediately upon receipt of due written proof of eligibility at Our administrative office. The Benefit Amount will be paid to You or Your estate unless You have otherwise assigned or designated benefits. We reserve the right to require the consent of a spouse, an Insured Person or other Beneficiaries.

If the qualifying Insured Person dies after You elect to receive the Benefit Amount, but before any such benefits are received, the election shall be cancelled and the death benefit paid pursuant to the policy.

Any acceleration of benefits paid will not reduce the benefit of other riders attached to Your policy, if applicable.

Terminal Illness Option. This option allows You to receive the Benefit Amount as a lump sum if an Insured Person is diagnosed with a Terminal Illness. The lump sum shall be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans. If You do not want to receive the payment in a lump sum, You can elect to be paid in 12 equal monthly payments. If You take 12 payments, We will pay interest of not less than one percent per year. If the qualifying Insured Person dies before all 12 payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payments.

Permanent Confinement Option. This option allows You to receive the Benefit Amount as a lump sum if an Insured Person:

- is diagnosed with a Permanent Confinement Condition; and
- has been confined to a Nursing Home for 90 consecutive days before You elect to receive the Benefit Amount.

The lump sum shall be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans. If You do not want to receive a lump sum payment, You can be paid level monthly payments over a period of your choosing provided it adheres to the requirements detailed in the table below. We will pay interest of not less than one percent per year.

Attained Age of Insured Person	Maximum Payment Period in Years
Under 64	10
65 – 67	8
68 - 70	7
71 – 73	6
74 – 77	5
78 – 81	4
82 – 86	3
87+	2

We can set a monthly maximum benefit. If the qualifying Insured Person dies before all payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payment.

RIDER REQUIREMENTS

Election Requirements. To elect this rider's Benefit Amount, You must:

- submit an application for benefits to our administrative office; and
- provide us with a Physician's statement confirming eligibility for this rider's benefits.

Upon request to accelerate the benefits We will provide You and any irrevocable Beneficiary a statement demonstrating the effect of acceleration of benefits on Your policy's death benefit, cash value, premiums and policy loans. This information will be provided to You and any irrevocable Beneficiary again upon payment of the Benefit Amount.

We will provide You with an application for benefits within 15 days of Your request. If We are unable to furnish You with an application within 15 days of Your request, it will be considered that You complied with the election requirements if You submit a Physician's written certification that an Insured Person has a Terminal Illness or a Permanent Confinement Condition.

General Requirements. You cannot elect to receive the Benefit Amount:

- if Your policy is on extended term insurance; or
- if You are required by law or government to use this rider to pay creditors' claims or to get a government benefit.

EFFECT ON POLICY

Following the payment of the Benefit Amount, the policy will stay in force at a reduced amount. The policy's death benefit will be reduced by the Accelerated Amount, but the policy's remaining Face Amount cannot be less than $10,000. We will provide You with an endorsement, which reflects the reduction of all values. Acceleration of benefits will have the following effect(s) on Your policy:

- the policy premium will be reduced to the premium that would apply had the policy been issued at the reduced Face Amount; and
- the policy cash value, if any, shall be reduced by the same percentage as the policy death benefit.

The amount an insured may elect is the lesser of $250,000 or the policy Face Amount in force plus any paid-up additions and less any Loan Balance.

If this rider is attached to a joint policy, the death benefit for the joint policy will be reduced by the Accelerated Amount as described above.

GENERAL PROVISIONS

Contestable Period. This rider is contestable on the same basis as the policy to which it is attached.

Reinstatement. If the policy is reinstated, this rider will be reinstated unless any Benefit Amount has been paid under this rider.

Termination. This rider will terminate on the earlier of the following dates:

- the date we approve your application to accelerate benefits;
- the date a policy split option is exercised;
- the date we receive your written notice to terminate this rider unless the notice specifies a later date; or
- the date your policy terminates for any reason.

If Your policy is assigned or has an irrevocable Beneficiary, a signed acknowledgement form must be submitted to Our administrative office.

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 Death Benefits Rider DISCLOSURE STATEMENT

ACCELERATED DEATH BENEFITS PAID UNDER THIS RIDER WILL REDUCE THE POLICY'S DEATH BENEFIT, PREMIUMS AND POLICY VALUES, WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE CASH VALUE.

BENEFITS PAID UNDER THIS RIDER MAY BE TAXABLE AND ARE NOT INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS.

This rider provides an accelerated payment of life insurance proceeds under conditions specified in this rider. It is not intended to provide health, nursing home or long-term care insurance. Cash values, loan values, if any, and death benefits will be reduced if you receive an accelerated benefit. Benefit payments may adversely affect qualifications for Medicaid or other government benefits or entitlement payments.

DEFINITIONS

Accelerated Amount means the portion of the Eligible Proceeds You elect to accelerate.

Benefit Amount means the portion of the Eligible Proceeds You elect to receive, adjusted by the Discount Factor.

Discount Factor means a factor that is applied to the death benefit being accelerated on the Election Date, which accounts for:

- reduced life expectancy;
- insured person's age and gender *(unless this policy was issued on a gender neutral basis, in which case male rates will be assumed)*;
- expected future premiums;
- current dividends, if any;
- interest rate. The maximum interest rate used will be no more than the greater of a) the current yield on 90-day treasury bills or b) the current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages—Monthly Average Corporates published by Moody's Investor Service, Inc., or successor thereto, for the calendar month ending two months before the date an accelerated payment is requested; and
- a one-time processing charge not to exceed $250. We will inform You of the charge when You request this rider's benefit.

Election Date means the date We receive Your application for the Benefit Amount.

Eligible Proceeds means the lesser of $250,000 or the policy Face Amount in force plus any paid-up additions and less any Loan Balance.

Immediate Family means the spouse, father, mother, children or siblings of an Insured Person.

Nursing Home means an institution which is not primarily a residential facility and is either:

- a Medicare-approved skilled nursing facility;
- state-licensed as a skilled nursing or intermediate care facility; or
- meets all of the following:
  - is state-licensed as a Nursing Home;
  - primarily provides nursing care;
  - is supervised by a registered or licensed practical nurse;
  - keeps daily patient medical records; and
  - records and controls all medications it gives.

Permanent Confinement Condition means a medical condition that is expected to require continuous permanent confinement in a Nursing Home for the remainder of an Insured Person's lifetime. Such a condition must be certified by a Physician.

Physician means a doctor of medicine or osteopathy who is duly licensed and practicing medicine in the United States and who is legally qualified to diagnose and treat sickness and injuries. Such Physician cannot be a member of an Insured Person's Immediate Family or business associate, and must be providing services within the scope of his or her license/specialty. Practitioners other than those named above are not Physicians.

Terminal Illness means a condition that results in an expected life span of 12 months or less. Such a condition must be certified by a Physician.

RIDER BENEFIT

Payment of Accelerated Benefits. If an Insured Person qualifies for the Terminal Illness Option or the Permanent Confinement Option, We will pay You the Benefit Amount. Payment will be made immediately upon receipt of due written proof of eligibility at Our administrative office. The Benefit Amount will be paid to You or Your estate unless You have otherwise assigned or designated benefits. We reserve the right to require the consent of a spouse, an Insured Person or other Beneficiaries.

If the qualifying Insured Person dies after You elect to receive the Benefit Amount, but before any such benefits are received, the election shall be cancelled and the death benefit paid pursuant to the policy.

Any acceleration of benefits paid will not reduce the benefit of other riders attached to Your policy, if applicable.

Terminal Illness Option. This option allows You to receive the Benefit Amount as a lump sum if an Insured Person is diagnosed with a Terminal Illness. The lump sum shall be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans. If You do not want to receive the payment in a lump sum, You can elect to be paid in 12 equal monthly payments. If You take 12 payments, We will pay interest of not less than one percent per year. If the qualifying Insured Person dies before all 12 payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payments.

Permanent Confinement Option. This option allows You to receive the Benefit Amount as a lump sum if an Insured Person:

- is diagnosed with a Permanent Confinement Condition; and
- has been confined to a Nursing Home for 90 consecutive days before You elect to receive the Benefit Amount.

The lump sum shall be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans. If You do not want to receive a lump sum payment, You can be paid level monthly payments over a period of your choosing provided it adheres to the requirements detailed in the table below. We will pay interest of not less than one percent per year.

Attained Age of Insured Person	Maximum Payment Period in Years
Under 64	10
65 – 67	8
68 - 70	7
71 – 73	6
74 – 77	5
78 – 81	4
82 – 86	3
87+	2

We can set a monthly maximum benefit. If the qualifying Insured Person dies before all payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payment.

RIDER REQUIREMENTS

Election Requirements. To elect this rider's Benefit Amount, You must:

- submit an application for benefits to our administrative office; and
- provide us with a Physician's statement confirming eligibility for this rider's benefits.

Upon request to accelerate the benefits We will provide You and any irrevocable Beneficiary a statement demonstrating the effect of acceleration of benefits on Your policy's death benefit, cash value, premiums and policy loans. This information will be provided to You and any irrevocable Beneficiary again upon payment of the Benefit Amount.

We will provide You with an application for benefits within 15 days of Your request. If We are unable to furnish You with an application within 15 days of Your request, it will be considered that You complied with the election requirements if You submit a Physician's written certification that an Insured Person has a Terminal Illness or a Permanent Confinement Condition.

General Requirements. You cannot elect to receive the Benefit Amount:

- if Your policy is on extended term insurance; or
- if You are required by law or government to use this rider to pay creditors' claims or to get a government benefit.

EFFECT ON POLICY

Following the payment of the Benefit Amount, the policy will stay in force at a reduced amount. The policy's death benefit will be reduced by the Accelerated Amount, but the policy's remaining Face Amount cannot be less than $10,000. We will provide You with an endorsement, which reflects the reduction of all values. Acceleration of benefits will have the following effect(s) on Your policy:

- the policy premium will be reduced to the premium that would apply had the policy been issued at the reduced Face Amount; and
- the policy cash value, if any, shall be reduced by the same percentage as the policy death benefit.

The amount an insured may elect is the lesser of $250,000 or the policy Face Amount in force plus any paid-up additions and less any Loan Balance.

If this rider is attached to a joint policy, the death benefit for the joint policy will be reduced by the Accelerated Amount as described above.

GENERAL PROVISIONS

Contestable Period. This rider is contestable on the same basis as the policy to which it is attached.

Reinstatement. If the policy is reinstated, this rider will be reinstated unless any Benefit Amount has been paid under this rider.

Termination. This rider will terminate on the earlier of the following dates:

- the date we approve your application to accelerate benefits;
- the date a policy split option is exercised;
- the date we receive your written notice to terminate this rider unless the notice specifies a later date; or
- the date your policy terminates for any reason.

If Your policy is assigned or has an irrevocable Beneficiary, a signed acknowledgement form must be submitted to Our administrative office.

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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Automatic PREMIUM PAYMENT

PLEASE PRINT WITH BLACK INK

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

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

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

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

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

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

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

Type of Account: ☐ Checking ☐ Savings

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

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

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

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

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

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 INDIVIDUAL LIFE INSURANCE

PLEASE PRINT IN BLUE OR BLACK INK

1. PROPOSED INSURED

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

Social Security No. | ☐ Male ☐ Female | Email | Age

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

Personal Phone No. ( ) | Birth State/Country | Height ft. in. | Weight lbs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Social Security No. | Relationship to Insured | Birth State/Country

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

Contingent Owner's Name (*First, Middle, Last*) | Contingent Owner's Relationship to Insured

3. BENEFICIARIES

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

Primary Beneficiary Name *(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

What amount was collected with this application? $

Type

☐ Direct Billing ☐ Automatic Bank Withdrawal
☐ List Billing *(employer)*

Frequency

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

Payor Name (*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.

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

3. ADDITIONAL BENEFICIARIES

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. If additional space is needed, attach a separate sheet of paper.

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

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

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

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

   If YES, check all that apply:
   ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/BASE Jumping/Hang Gliding
   ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports
   ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning

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

   If YES, please explain _____

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

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

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

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

   If YES, please explain _____

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

   If YES, please explain _____

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

   If YES, please explain _____

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

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

   If YES, please explain _____

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

   If YES, please explain _____

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

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

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

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

10. a. Does any Proposed Insured have other annuity or life insurance coverage in force? ☐ Yes ☐ No
    If YES, provide details below.

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

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

Company Name	Type of Coverage	Amount of Coverage

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

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

HEALTH SECTION

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

1. During the past **10 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:

   a. Heart disorder, including a heart attack *(myocardial infarction)*, angina, irregular heartbeat or abnormal heart rhythm *(arrhythmia)*, chest pain, hypertension *(high blood pressure)*, heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack *(TIA or mini-stroke)*, or rheumatic fever? ☐ Yes ☐ No

   b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease *(other than kidney stones)*, protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? ☐ Yes ☐ No

   c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? ☐ Yes ☐ No

   d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation *(including Down syndrome)*, multiple sclerosis *(MS)*, muscular dystrophy *(MD)*, Parkinson's disease, amyotrophic lateral sclerosis *(ALS)*, any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy? ☐ Yes ☐ No

   e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease *(COPD)*, shortness of breath, or asthma or other respiratory disorder? ☐ Yes ☐ No

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

   g. Arthritis in any form, fibromyalgia, paralysis or connective tissue disorder *(such as lupus or scleroderma)* or any disease or disorder of the back, spine, bones, joints or muscles? ☐ Yes ☐ No

   h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? ☐ Yes ☐ No

   i. Any disease or disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No

2. During the past **10 years**, has any Proposed Insured:

   a. Required a transfusion of whole blood or blood products, including platelets, packed red blood cells or plasma? ☐ Yes ☐ No

   b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? ☐ Yes ☐ No

   c. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? ☐ Yes ☐ No

   d. Been diagnosed or treated by a medical professional for acquired immunedeficiency syndrome *(AIDS)*, AIDS-related complex *(ARC)* or antibodies to human T-lymphotropic virus type III *(HTLV)*; or had a positive test for human immunodeficiency virus *(HIV)* antibodies? ☐ Yes ☐ No

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

   a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? ☐ Yes ☐ No

   b. Been advised to have any test *(except HIV tests)*, treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received? ☐ Yes ☐ No

   c. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests *(other than AIDS-related blood tests)* or urine tests? ☐ Yes ☐ No

4. Has any Proposed Insured had a natural parent or sibling who was diagnosed by a medical professional with or died of cancer, heart disease, diabetes, Huntington's disease or polycystic kidney disease prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death. ☐ Yes ☐ No

   _____

5. a. Has any Proposed Insured **ever** been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No

   b. Is any Proposed Insured currently pregnant? ☐ Yes ☐ No

   If YES, date child is expected *(MM/DD/YYYY)* ____/____/_____

6. Is any Proposed Insured currently taking any prescription medication? ☐ Yes ☐ No

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

SUPPLEMENTAL INFORMATION

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

Additional Information:

LIFE PRODUCT SECTION

1. What is the purpose of this insurance? ☐ Personal ☐ Key Person ☐ Buy/Sell ☐ Business Loan ☐ Charitable Giving ☐ Other _____

2. a. Are there any agreements in place to assign/sell the policy? ..... ☐ Yes ☐ No

b. Is there any intent to sell the policy after issuance? ..... ☐ Yes ☐ No

c. Has the insured undergone any life expectancy or health exams in conjunction with a life insurance application or settlement option contract? ☐ Yes ☐ No

TERM LIFE INSURANCE

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

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

☐ Disability Waiver of Premium Rider

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

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

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

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

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

☐ Critical Illness Benefit Rider for Primary Insured $ _____

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

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

☐ Endowment Benefit Rider

WHOLE LIFE INSURANCE

Face Amount $ _____

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

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

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

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

☐ Disability Waiver of Premium Benefit Rider

☐ Protected Insurability Benefit Rider $ _____

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

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

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

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

☐ Critical Illness Benefit Rider for Primary Insured $ _____

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

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

☐ 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 Purchase Option *(VER)* ☐ Periodic Premiums $ _____ ☐ Single Premium $ _____

SINGLE PREMIUM WHOLE LIFE INSURANCE

Face Amount $ _____ ☐ Single Premium Insurance Rider $ _____

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

LIFE PRODUCT SECTION *(continued)*

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

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name *(First, Middle, Last)*				
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	☐ 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 and Occupation/Duties	
Personal Phone No.	
Gross monthly income	$
If self-employed, net monthly income	$

1. Has any proposed insured child **ever**:
   a. Been diagnosed with or treated for internal cancer or tumor, lymphoma, leukemia, disorder of the lymph nodes or glandular disorder? ..... ☐ Yes ☐ No
   b. Been diagnosed with or treated for heart disease or disorder? ..... ☐ Yes ☐ No
2. During the past **5 years**, has any proposed insured child been advised by a member of the medical profession to have any diagnostic tests performed but not completed, or for which the results are currently unknown or pending (excluding HIV tests)? ..... ☐ 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)* / /

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

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

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

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

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

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

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

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

Phone No. ( ) _____ Fax No. ( ) _____

Reason for consultation _____

Results _____

UNIVERSAL LIFE PRODUCT SECTION

1. What is the purpose of this insurance? ☐ Personal ☐ Key Person ☐ Buy/Sell ☐ Business Loan ☐ Charitable Giving ☐ Other _____

2. a. Are there any agreements in place to assign/sell the policy? ..... ☐ Yes ☐ No

b. Is there any intent to sell the policy after issuance? ..... ☐ Yes ☐ No

c. Has the insured undergone any life expectancy or health exams in conjunction with a life insurance application or settlement option contract? ☐ Yes ☐ No

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

Planned Periodic Premium $ _____ Special Policy Date *(if desired)* ___/___/___

ADDITIONAL BENEFITS

Check rider(s) desired and indicate amount requested.

PRIMARY INSURED RIDERS

☐ Level Term Rider $ _____ face amt.
☐ 10 years ☐ 20 years

☐ Critical Illness Rider $ _____ benefit amt.

☐ Accident-only Disability Income Rider $ _____ mo. benefit

☐ Disability Income Rider $ _____ mo. benefit

☐ Face Amount Increase Rider $ _____ face amt.

☐ Accidental Death Rider

☐ Disability Waiver Rider

OTHER INSURED RIDERS

☐ Other Insured Level Term Rider $ _____ face amt.
☐ 10 years ☐ 20 years

☐ Other Insured Critical Illness Rider $ _____ benefit amt.

☐ Accident-only Disability Income Rider $ _____ mo. benefit

☐ Disability Income Rider $ _____ mo. benefit

CHILD(REN) INSURED RIDER

☐ Children's Term Rider _____ units

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

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name *(First, Middle, Last)*				
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	☐ 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 and Occupation/Duties				
Personal Phone No				
Gross monthly income	$			
If self-employed, net monthly income	$			

1. Has any proposed insured child **ever**:
   a. Been diagnosed with or treated for internal cancer or tumor, lymphoma, leukemia, disorder of the lymph nodes or glandular disorder? ..... ☐ Yes ☐ No
   b. Been diagnosed with or treated for heart disease or disorder? ..... ☐ Yes ☐ No
2. During the past **5 years**, has any proposed insured child been advised by a member of the medical profession to have any diagnostic tests performed but not completed, or for which the results are currently unknown or pending (excluding HIV tests)? ..... ☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

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

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

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

Phone No. (___) _____ Fax No. (___) _____

Reason for consultation _____

Results _____

PHYSICIAN INFORMATION

Please list the last physician consulted:

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

Address _____
Street Address *Suite*

_____
City *State* *ZIP+4*

Phone No. (____) _____ Fax No. (____) _____

Is this your primary physician? ☐ Yes ☐ No

Reason for consultation _____

Results _____

_____

AGREEMENT

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

I *(We)* agree that:

a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.

b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and the answers on the application remain true, complete and accurate as of the date the first full premium is paid. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.

c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

d. If the Policyowner is someone other than the Insured, in the event of the Policyowner's death (and no Contingent Owner(s) living), the Insured will become the Policyowner.

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

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

Signed at _____ 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 Licensed Agent *Print Agent Name and Agent No.*

AGENT STATEMENT

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

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

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

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

   c. Did the Proposed Insured approach you to purchase insurance? If YES, list their stated need for the insurance _____ ☐ Yes ☐ No

   d. Did the Proposed Insured(s) directly respond to you regarding each application question? ☐ Yes ☐ No

   e. Was a government-issued picture ID requested and reviewed for the Proposed Insured, Owner and Payor? ☐ Yes ☐ No

   f. Was each Proposed Insured present, and did you witness their signatures at the time the application was taken? ☐ Yes ☐ No

   g. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured(s)? If YES, please provide details below. ☐ 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 REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.

   ☐ Paramedical examination ☐ Blood sample ☐ Urine sample ☐ Electrocardiogram *(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 Name _____ Agent's No. _____ _____ %

   Agent Name _____ Agent's 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 employer authorization form 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:

☐ Preferred Plus 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:

☐ Preferred Plus 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 Plus NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification: _____

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

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Confidential Information Authorization

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Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

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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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_____ / / _____
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)

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

Confidential Information Authorization for Release of Psychotherapy Notes

_____ / / _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

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

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

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

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

- Psychotherapy notes

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

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

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

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

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

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

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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

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Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

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

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

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- Psychotherapy notes

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

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

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

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

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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
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(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
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)

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

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

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

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

MAXIMUM AMOUNT LIMITATION

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

REFUND OF PAYMENT

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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)

ASSURITY® LIFE INSURANCE COMPANY
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(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

CONSENT FOR TESTING

WRITTEN CONSENT FOR HIV ANTIBODY TESTING

(Conventional Testing—Not for Use with a Rapid HIV Test)

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

Test Subject or No. _____ Date *(MM/DD/YYYY)* _____ Time _____ (AM) (PM)

I hereby grant my permission for a test to detect whether I have antibodies to HIV *(Human Immunodeficiency Virus)* in my body.

HIV testing is voluntary and requires your consent in writing. The purpose of HIV antibody testing is to show whether you are infected with HIV, the virus that causes AIDS *(Acquired Immune Deficiency Syndrome)*.

Any test result that indicates that antibodies for HIV are present is considered positive for HIV infection.

Before you consent to be tested for HIV, your healthcare provider should speak to you about:

- How HIV is passed from person to person and mother to baby;
- Steps to take that may prevent the transmission of HIV; and
- The meaning of an HIV antibody test result.

If you agree with the following statements and want to consent to HIV testing, please sign this form.

I have been counseled about the benefits of having an HIV test and understand that:

- Human immunodeficiency virus *(HIV)* is the virus that causes AIDS;
- HIV is spread by sexual intercourse, so all sexually active persons are potentially at risk for HIV infection;
- HIV is spread by sharing needles with another person during injection of drugs, so all injection drug users are potentially at risk for HIV infection;
- HIV can be passed from a mother to her baby during pregnancy, at delivery and through breastfeeding; and
- HIV antibody test results are confidential, and the law protects me from discrimination.

I understand that a positive result does not mean I have AIDS, but indicates that I have HIV infection.

I understand that if my test results are positive, I will be offered HIV counseling.

I understand that test results may indicate that a person has HIV antibodies when the person does not have the antibodies *(a false positive result)* or the test may fail to detect that a person has antibodies to the virus when the person does in fact have these antibodies *(a false negative result)*.

If my HIV antibody test result is negative, no further testing will be done at this time. A negative HIV antibody test result most likely means that I am not infected with HIV, but it may not detect a recent infection.

If my HIV antibody test result is positive, this means that antibodies to the virus were detected and that I am HIV infected.

Confidentiality of HIV Information:

If you take the rapid HIV test, your test results are confidential. Under Illinois law, confidential HIV information can be given only to people to whom you allow it to be given by your written approval, to people who need to know your HIV status in order to provide medical care and services, including: an authorized agent or employee of a health facility or a healthcare provider if the health facility or provider is authorized to obtain test results; those who are exposed to blood/body fluids in the course of their employment; and organizations that review the services you receive.

The law also allows your confirmed HIV test results to be released: to public health officials as required by law; for payment for care and treatment; to a temporary caretaker of children taken into protective custody by the Illinois Department of Children and Family Services; and to any other entity permitted by the AIDS Confidentiality Act.

I understand that my test results will be kept confidential to the extent provided by law. In addition, I understand that I may withdraw from the testing at any point in time prior to the completion of laboratory tests. I understand that my testing is voluntary.

I agree to be tested and I agree that I may be told my test results.

I agree that if the result of my HIV test is positive I may be referred to another healthcare provider for follow-up testing and care.

I have been advised about the purpose, potential uses, limitations and meaning of the test results; the voluntary nature of the test; the right to withdraw consent at any time prior to the completion of laboratory tests; and the confidentiality protections under the law.

The information presented above has been completely and clearly explained to me, and all of my questions have been answered. I hereby authorize my physician or facility to collect an oral or blood specimen and perform an HIV antibody test on that specimen.

_____ _____
Patient/Client Signature or Signature of Legally Authorized Representative *Date (MM/DD/YYYY)*

_____ _____
Facility/Provider Witness *Date (MM/DD/YYYY)*

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

Life Insurance or Annuity
REPLACEMENT NOTICE

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or insurance producer that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in *your* best interest.

We are required by law to notify your existing company that you may be replacing their policy.

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

_____ _____
Insurance Producer's Signature and Printed Name *Date (MM/DD/YYYY)*

LIST BELOW THE IDENTIFICATION OF POLICIES WHICH ARE INVOLVED IN THE REPLACEMENT TRANSACTION:

INSURER	CONTRACT NO.	NAME OF INSURED

To be completed if replacing another policy.
Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

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

Life Insurance or Annuity
REPLACEMENT NOTICE

NOTICE REGARDING PROPOSED REPLACEMENT OF LIFE INSURANCE POLICY OR ANNUITY

Name of Existing Insurer _____

Insurer's Address _____
Mailing Address *City* *State* *Zip Code*

To Whom It May Concern:

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity(ies) for an individual presently insured with your company.

Identification

Name of Insured _____
First *M.I.* *Last*

Insured's Address _____
Mailing Address *City* *State* *Zip Code*

Contract Number(s) _____ _____

_____ _____

_____ _____

_____ _____

This notice is given pursuant to 50 Ill. Adm. Code 917.70(c)

_____ _____
Insurance Producer's Signature and Printed Name *Date (MM/DD/YYYY)*

To be completed if replacing another policy
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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Life Insurance or Annuity
REPLACEMENT NOTICE

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or insurance producer that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in *your* best interest.

We are required by law to notify your existing company that you may be replacing their policy.

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

_____ _____
Insurance Producer's Signature and Printed Name *Date (MM/DD/YYYY)*

LIST BELOW THE IDENTIFICATION OF POLICIES WHICH ARE INVOLVED IN THE REPLACEMENT TRANSACTION:

INSURER	CONTRACT NO.	NAME OF INSURED

To be completed if replacing another policy.
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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Life Insurance or Annuity
REPLACEMENT NOTICE

NOTICE REGARDING PROPOSED REPLACEMENT OF LIFE INSURANCE POLICY OR ANNUITY

Name of Existing Insurer _____

Insurer's Address _____
Mailing Address *City* *State* *Zip Code*

To Whom It May Concern:

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity(ies) for an individual presently insured with your company.

Identification

Name of Insured _____
First *M.I.* *Last*

Insured's Address _____
Mailing Address *City* *State* *Zip Code*

Contract Number(s) _____ _____

_____ _____

_____ _____

_____ _____

This notice is given pursuant to 50 Ill. Adm. Code 917.70(c)

_____ _____
Insurance Producer's Signature and Printed Name *Date (MM/DD/YYYY)*

To be completed if replacing another policy
Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

ASSURITY® LIFE INSURANCE COMPANY
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(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

Accelerated Death Benefits Rider DISCLOSURE STATEMENT

ACCELERATED DEATH BENEFITS PAID UNDER THIS RIDER WILL REDUCE THE POLICY'S DEATH BENEFIT, PREMIUMS AND POLICY VALUES, WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE CASH VALUE.

BENEFITS PAID UNDER THIS RIDER MAY BE TAXABLE AND ARE NOT INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS.

This rider provides an accelerated payment of life insurance proceeds under conditions specified in this rider. It is not intended to provide health, nursing home or long-term care insurance. Cash values, loan values, if any, and death benefits will be reduced if you receive an accelerated benefit. Benefit payments may adversely affect qualifications for Medicaid or other government benefits or entitlement payments.

DEFINITIONS

Accelerated Amount means the portion of the Eligible Proceeds You elect to accelerate.

Benefit Amount means the portion of the Eligible Proceeds You elect to receive, adjusted by the Discount Factor.

Discount Factor means a factor that is applied to the death benefit being accelerated on the Election Date, which accounts for:

- reduced life expectancy;
- insured person's age and gender *(unless this policy was issued on a gender neutral basis, in which case male rates will be assumed)*;
- expected future premiums;
- current dividends, if any;
- interest rate. The maximum interest rate used will be no more than the greater of a) the current yield on 90-day treasury bills or b) the current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages—Monthly Average Corporates published by Moody's Investor Service, Inc., or successor thereto, for the calendar month ending two months before the date an accelerated payment is requested; and
- a one-time processing charge not to exceed $250. We will inform You of the charge when You request this rider's benefit.

Election Date means the date We receive Your application for the Benefit Amount.

Eligible Proceeds means the lesser of $250,000 or the policy Face Amount in force plus any paid-up additions and less any Loan Balance.

Immediate Family means the spouse, father, mother, children or siblings of an Insured Person.

Nursing Home means an institution which is not primarily a residential facility and is either:

- a Medicare-approved skilled nursing facility;
- state-licensed as a skilled nursing or intermediate care facility; or
- meets all of the following:
  - is state-licensed as a Nursing Home;
  - primarily provides nursing care;
  - is supervised by a registered or licensed practical nurse;
  - keeps daily patient medical records; and
  - records and controls all medications it gives.

Permanent Confinement Condition means a medical condition that is expected to require continuous permanent confinement in a Nursing Home for the remainder of an Insured Person's lifetime. Such a condition must be certified by a Physician.

Physician means a doctor of medicine or osteopathy who is duly licensed and practicing medicine in the United States and who is legally qualified to diagnose and treat sickness and injuries. Such Physician cannot be a member of an Insured Person's Immediate Family or business associate, and must be providing services within the scope of his or her license/specialty. Practitioners other than those named above are not Physicians.

Terminal Illness means a condition that results in an expected life span of 12 months or less. Such a condition must be certified by a Physician.

RIDER BENEFIT

Payment of Accelerated Benefits. If an Insured Person qualifies for the Terminal Illness Option or the Permanent Confinement Option, We will pay You the Benefit Amount. Payment will be made immediately upon receipt of due written proof of eligibility at Our administrative office. The Benefit Amount will be paid to You or Your estate unless You have otherwise assigned or designated benefits. We reserve the right to require the consent of a spouse, an Insured Person or other Beneficiaries.

If the qualifying Insured Person dies after You elect to receive the Benefit Amount, but before any such benefits are received, the election shall be cancelled and the death benefit paid pursuant to the policy.

Any acceleration of benefits paid will not reduce the benefit of other riders attached to Your policy, if applicable.

Terminal Illness Option. This option allows You to receive the Benefit Amount as a lump sum if an Insured Person is diagnosed with a Terminal Illness. The lump sum shall be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans. If You do not want to receive the payment in a lump sum, You can elect to be paid in 12 equal monthly payments. If You take 12 payments, We will pay interest of not less than one percent per year. If the qualifying Insured Person dies before all 12 payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payments.

Permanent Confinement Option. This option allows You to receive the Benefit Amount as a lump sum if an Insured Person:

- is diagnosed with a Permanent Confinement Condition; and
- has been confined to a Nursing Home for 90 consecutive days before You elect to receive the Benefit Amount.

The lump sum shall be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans. If You do not want to receive a lump sum payment, You can be paid level monthly payments over a period of your choosing provided it adheres to the requirements detailed in the table below. We will pay interest of not less than one percent per year.

Attained Age of Insured Person	Maximum Payment Period in Years
Under 64	10
65 – 67	8
68 - 70	7
71 – 73	6
74 – 77	5
78 – 81	4
82 – 86	3
87+	2

We can set a monthly maximum benefit. If the qualifying Insured Person dies before all payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payment.

RIDER REQUIREMENTS

Election Requirements. To elect this rider's Benefit Amount, You must:

- submit an application for benefits to our administrative office; and
- provide us with a Physician's statement confirming eligibility for this rider's benefits.

Upon request to accelerate the benefits We will provide You and any irrevocable Beneficiary a statement demonstrating the effect of acceleration of benefits on Your policy's death benefit, cash value, premiums and policy loans. This information will be provided to You and any irrevocable Beneficiary again upon payment of the Benefit Amount.

We will provide You with an application for benefits within 15 days of Your request. If We are unable to furnish You with an application within 15 days of Your request, it will be considered that You complied with the election requirements if You submit a Physician's written certification that an Insured Person has a Terminal Illness or a Permanent Confinement Condition.

General Requirements. You cannot elect to receive the Benefit Amount:

- if Your policy is on extended term insurance; or
- if You are required by law or government to use this rider to pay creditors' claims or to get a government benefit.

EFFECT ON POLICY

Following the payment of the Benefit Amount, the policy will stay in force at a reduced amount. The policy's death benefit will be reduced by the Accelerated Amount, but the policy's remaining Face Amount cannot be less than $10,000. We will provide You with an endorsement, which reflects the reduction of all values. Acceleration of benefits will have the following effect(s) on Your policy:

- the policy premium will be reduced to the premium that would apply had the policy been issued at the reduced Face Amount; and
- the policy cash value, if any, shall be reduced by the same percentage as the policy death benefit.

The amount an insured may elect is the lesser of $250,000 or the policy Face Amount in force plus any paid-up additions and less any Loan Balance.

If this rider is attached to a joint policy, the death benefit for the joint policy will be reduced by the Accelerated Amount as described above.

GENERAL PROVISIONS

Contestable Period. This rider is contestable on the same basis as the policy to which it is attached.

Reinstatement. If the policy is reinstated, this rider will be reinstated unless any Benefit Amount has been paid under this rider.

Termination. This rider will terminate on the earlier of the following dates:

- the date we approve your application to accelerate benefits;
- the date a policy split option is exercised;
- the date we receive your written notice to terminate this rider unless the notice specifies a later date; or
- the date your policy terminates for any reason.

If Your policy is assigned or has an irrevocable Beneficiary, a signed acknowledgement form must be submitted to Our administrative office.

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 Death Benefits Rider DISCLOSURE STATEMENT

ACCELERATED DEATH BENEFITS PAID UNDER THIS RIDER WILL REDUCE THE POLICY'S DEATH BENEFIT, PREMIUMS AND POLICY VALUES, WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE CASH VALUE.

BENEFITS PAID UNDER THIS RIDER MAY BE TAXABLE AND ARE NOT INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS.

This rider provides an accelerated payment of life insurance proceeds under conditions specified in this rider. It is not intended to provide health, nursing home or long-term care insurance. Cash values, loan values, if any, and death benefits will be reduced if you receive an accelerated benefit. Benefit payments may adversely affect qualifications for Medicaid or other government benefits or entitlement payments.

DEFINITIONS

Accelerated Amount means the portion of the Eligible Proceeds You elect to accelerate.

Benefit Amount means the portion of the Eligible Proceeds You elect to receive, adjusted by the Discount Factor.

Discount Factor means a factor that is applied to the death benefit being accelerated on the Election Date, which accounts for:

- reduced life expectancy;
- insured person's age and gender *(unless this policy was issued on a gender neutral basis, in which case male rates will be assumed)*;
- expected future premiums;
- current dividends, if any;
- interest rate. The maximum interest rate used will be no more than the greater of a) the current yield on 90-day treasury bills or b) the current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages—Monthly Average Corporates published by Moody's Investor Service, Inc., or successor thereto, for the calendar month ending two months before the date an accelerated payment is requested; and
- a one-time processing charge not to exceed $250. We will inform You of the charge when You request this rider's benefit.

Election Date means the date We receive Your application for the Benefit Amount.

Eligible Proceeds means the lesser of $250,000 or the policy Face Amount in force plus any paid-up additions and less any Loan Balance.

Immediate Family means the spouse, father, mother, children or siblings of an Insured Person.

Nursing Home means an institution which is not primarily a residential facility and is either:

- a Medicare-approved skilled nursing facility;
- state-licensed as a skilled nursing or intermediate care facility; or
- meets all of the following:
  - is state-licensed as a Nursing Home;
  - primarily provides nursing care;
  - is supervised by a registered or licensed practical nurse;
  - keeps daily patient medical records; and
  - records and controls all medications it gives.

Permanent Confinement Condition means a medical condition that is expected to require continuous permanent confinement in a Nursing Home for the remainder of an Insured Person's lifetime. Such a condition must be certified by a Physician.

Physician means a doctor of medicine or osteopathy who is duly licensed and practicing medicine in the United States and who is legally qualified to diagnose and treat sickness and injuries. Such Physician cannot be a member of an Insured Person's Immediate Family or business associate, and must be providing services within the scope of his or her license/specialty. Practitioners other than those named above are not Physicians.

Terminal Illness means a condition that results in an expected life span of 12 months or less. Such a condition must be certified by a Physician.

RIDER BENEFIT

Payment of Accelerated Benefits. If an Insured Person qualifies for the Terminal Illness Option or the Permanent Confinement Option, We will pay You the Benefit Amount. Payment will be made immediately upon receipt of due written proof of eligibility at Our administrative office. The Benefit Amount will be paid to You or Your estate unless You have otherwise assigned or designated benefits. We reserve the right to require the consent of a spouse, an Insured Person or other Beneficiaries.

If the qualifying Insured Person dies after You elect to receive the Benefit Amount, but before any such benefits are received, the election shall be cancelled and the death benefit paid pursuant to the policy.

Any acceleration of benefits paid will not reduce the benefit of other riders attached to Your policy, if applicable.

Terminal Illness Option. This option allows You to receive the Benefit Amount as a lump sum if an Insured Person is diagnosed with a Terminal Illness. The lump sum shall be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans. If You do not want to receive the payment in a lump sum, You can elect to be paid in 12 equal monthly payments. If You take 12 payments, We will pay interest of not less than one percent per year. If the qualifying Insured Person dies before all 12 payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payments.

Permanent Confinement Option. This option allows You to receive the Benefit Amount as a lump sum if an Insured Person:

- is diagnosed with a Permanent Confinement Condition; and
- has been confined to a Nursing Home for 90 consecutive days before You elect to receive the Benefit Amount.

The lump sum shall be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans. If You do not want to receive a lump sum payment, You can be paid level monthly payments over a period of your choosing provided it adheres to the requirements detailed in the table below. We will pay interest of not less than one percent per year.

Attained Age of Insured Person	Maximum Payment Period in Years
Under 64	10
65 – 67	8
68 - 70	7
71 – 73	6
74 – 77	5
78 – 81	4
82 – 86	3
87+	2

We can set a monthly maximum benefit. If the qualifying Insured Person dies before all payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payment.

RIDER REQUIREMENTS

Election Requirements. To elect this rider's Benefit Amount, You must:

- submit an application for benefits to our administrative office; and
- provide us with a Physician's statement confirming eligibility for this rider's benefits.

Upon request to accelerate the benefits We will provide You and any irrevocable Beneficiary a statement demonstrating the effect of acceleration of benefits on Your policy's death benefit, cash value, premiums and policy loans. This information will be provided to You and any irrevocable Beneficiary again upon payment of the Benefit Amount.

We will provide You with an application for benefits within 15 days of Your request. If We are unable to furnish You with an application within 15 days of Your request, it will be considered that You complied with the election requirements if You submit a Physician's written certification that an Insured Person has a Terminal Illness or a Permanent Confinement Condition.

General Requirements. You cannot elect to receive the Benefit Amount:

- if Your policy is on extended term insurance; or
- if You are required by law or government to use this rider to pay creditors' claims or to get a government benefit.

EFFECT ON POLICY

Following the payment of the Benefit Amount, the policy will stay in force at a reduced amount. The policy's death benefit will be reduced by the Accelerated Amount, but the policy's remaining Face Amount cannot be less than $10,000. We will provide You with an endorsement, which reflects the reduction of all values. Acceleration of benefits will have the following effect(s) on Your policy:

- the policy premium will be reduced to the premium that would apply had the policy been issued at the reduced Face Amount; and
- the policy cash value, if any, shall be reduced by the same percentage as the policy death benefit.

The amount an insured may elect is the lesser of $250,000 or the policy Face Amount in force plus any paid-up additions and less any Loan Balance.

If this rider is attached to a joint policy, the death benefit for the joint policy will be reduced by the Accelerated Amount as described above.

GENERAL PROVISIONS

Contestable Period. This rider is contestable on the same basis as the policy to which it is attached.

Reinstatement. If the policy is reinstated, this rider will be reinstated unless any Benefit Amount has been paid under this rider.

Termination. This rider will terminate on the earlier of the following dates:

- the date we approve your application to accelerate benefits;
- the date a policy split option is exercised;
- the date we receive your written notice to terminate this rider unless the notice specifies a later date; or
- the date your policy terminates for any reason.

If Your policy is assigned or has an irrevocable Beneficiary, a signed acknowledgement form must be submitted to Our administrative office.

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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Automatic PREMIUM PAYMENT

PLEASE PRINT WITH BLACK INK

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

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

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

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

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

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

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

Type of Account: ☐ Checking ☐ Savings

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

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

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

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

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