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

Acci-Flex

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:

✓ The application should coincide with the **state in which the policy owner resides** for the following states:

- FL, MT and VT

All other applications should coincide with **the state in which the application is to be signed**.

✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state coinciding with the application used.**

✓ Use **age last birthday** when preparing illustrations and/or calculating insurance premiums.

✓ Obtain all required signatures.

✓ Have the proposed insured initial any changes. Corrections with white correction fluid/tape are not acceptable.

✓ Comply with all state regulations.

✓ Complete all other pertinent and applicable forms padded together in this application.

✓ If faxing an application directly to the home office, fax to (877) 864-6630.

✓ If mailing directly to the home office, address to:

Assurity Life Insurance Company
Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

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

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

Application for INSURANCE

PLEASE PRINT WITH BLACK INK

1. PROPOSED INSURED

First / Middle / Last — Legal Name	Date of Birth (MM/DD/YYYY) / /
Social Security No. - - ☐ Male ☐ Female	E-mail / Age
Street Address / City / State / ZIP+4 — Home Address	
Personal Phone No. ( )	Birth State/Country / Gross monthly income $

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

If YES, and you have permanent resident status, please list your permanent resident *(green card)* number _____

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

First / Middle / Last — Policyowner	Home Address: Street Address / City / State / ZIP+4
Social Security No. - -	Relationship to Insured / Birth State/ Country / Date of Birth (MM/DD/YYYY) / /

2. SECONDARY ADDRESSEE

First / Middle / Last — Legal Name	Relationship to Insured
Street Address / City / State / ZIP+4 — Home Address	

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

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 %**
			/ /	
			/ /	

4. PRODUCT INFORMATION

Base Amount $ _____ Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Monthly *(Auto Bank Withdrawal)* ☐ ~~Monthly *(Credit Card)*~~

Optional Benefits: ☐ ~~Waiver of Premium Rider~~ ☐ ~~Return of Premium Rider~~ ☐ Accident Only Disability Income Benefit Rider $ _____ Monthly Benefit

5. RIDER INFORMATION

If the Proposed Insured is applying for the Accident Only Disability Income Rider and/or the Waiver of Premium Rider: *Years Months*

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

Primary Employer *Company Name, Occupation, Duties*

6. STATEMENT OF HEALTH

Has the Proposed Insured ever been tested positive for the HIV *(human immunodeficiency virus)* infection or been diagnosed as having ARC *(AIDS-related complex)* or AIDS *(acquired immune deficiency syndrome)* caused by the HIV infection or other sickness or condition derived from such infection? ..... ☐ Yes ☐ No

7. OTHER INSURANCE INFORMATION—If additional space is needed, attach a separate sheet of paper.

1. Does the Proposed Insured have any other insurance coverage in force? If YES, please provide details below. ..... ☐ Yes ☐ No

Insurance Company Name	Pending or In Force	Life Insurance or Annuity Amt.	Disability Insurance Amt.	Being Replaced?
				☐ Yes ☐ No
				☐ Yes ☐ No

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

8. AGREEMENT

I *(We)* agree that:

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

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Signed at _____ on _____ / / _____

City *State* *Date (MM/DD/YYYY)*

_____ _____

Signature of Proposed Insured *Signature of Policyowner (if other than Proposed Insured)*

9. AGENT'S STATEMENT AND AGREEMENT

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

2. Has a Conditional Receipt been given to the Policyowner? ..... ☐ Yes ☐ No

3. Has the Proposed Insured signed a Confidential Information Authorization and been given a Fair Credit and MIB Notification? ..... ☐ Yes ☐ No

I hereby certify that I have accurately recorded in this application all information supplied by the Proposed Insured/Policyowner. The Proposed Insured/Policyowner has read the completed application, or has had the completed application read to them. I also certify that this insurance ☐ does ☐ does not replace or change any existing life, health or annuity coverage.

_____ / / _____ ( ) / ( ) _____

Signature of Soliciting Agent *Date (MM/DD/YYYY)* *Business Phone No. and Fax No.*

_____ _____ _____

Soliciting Agent's Printed Name *Florida License No.* *Agent's E-mail*

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Acci-Flex
DISCLOSURE STATEMENT

Payment of Proceeds:

The face amount of the policy will only be paid to the named beneficiary if the insured dies as a direct result of an accidental bodily injury. An accidental death is one which results directly from an accidental bodily injury suffered while the policy is in force and is independent of all other causes. Accidental death must occur within 90 days of the date of the insured's accidental bodily injury, and prior to the policy anniversary nearest the insured's 75th birthday, and while the policy is in force. No benefits are payable if the insured's death results from a cause other than an accidental bodily injury.

If there is an Accident Only Disability Rider attached to the policy, the Monthly Benefit will only be paid to the insured if the insured's total disability results from an accidental bodily injury.

I acknowledge the receipt of this Acci-Flex Disclosure Statement.

/ /		
Date (MM/DD/YYYY)	*Signature of Proposed Insured*	*Print Name of Proposed Insured*
/ /		
Date (MM/DD/YYYY)	*Signature of Policyowner (if other than Proposed Insured)*	*Print Name of Policyowner (if applicable)*
/ /		
Date (MM/DD/YYYY)	*Signature of Licensed Agent*	*Print Agent Name and Agent No.*

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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.

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Temporary Conditional Insurance Agreement

(for use with all Health products)

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

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

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

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

TERMS AND CONDITIONS

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

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

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

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

MAXIMUM AMOUNT LIMITATION

Assurity's liability under this Agreement is limited to:

- $2,500 of disability coverage or business overhead coverage;
- The amount of hospital indemnity coverage applied for; or
- $50,000 of critical illness coverage, including any other critical illness coverage applied for with Assurity.

These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.

REFUND OF PAYMENT

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

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

Dated at _____ On _____
City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

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Accident or Sickness Insurance
REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

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

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

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

4. New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

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

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

_____ _____
Date (MM/DD/YYYY) *Witness's Signature and Printed Name (Writing Agent)*

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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Automatic PREMIUM PAYMENT

PLEASE PRINT WITH BLACK INK

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

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

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

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

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account listed below for all premiums. I understand that initiating automatic payments may result in additional drafts to bring my account current. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account. I further understand that if the date of the withdrawal is after the policy issue date and the premium is not honored, my policy may lapse and require evidence of insurability for reinstatement.

☐ Do not draft initial premium: ☐ Payment enclosed or ☐ Payment collected on delivery

Type of Account: ☐ Checking ☐ Savings

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

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

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

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

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