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

Application for 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 | E-mail | Age

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

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

During the past **12 months**, has the Proposed Insured used any form of tobacco, nicotine-based products or substitutes such as patches or gum? ☐ Yes ☐ No

If YES, please list type: amount per day: last date of use (MM/DD/YYYY) / /

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

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

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

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 form 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) | E-mail

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 form.

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

4. PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below.

Type

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

Frequency

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

Payor Name (First, Middle, Last) | Billing Address (Street Address, City, State, ZIP+4)

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

5. SECONDARY ADDRESSEE

Legal Name (First, Middle, Last) | Relationship to Insured

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

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or within the next **12 months** intend to join, the National Guard or military? ☐ Yes ☐ No

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

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

   b. Has any Proposed Insured participated in, or planning participation in, any of the hazardous sports or activities listed below? ☐ Yes ☐ No

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

3. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No
   If YES, please list Proposed Insured's name, amount of weight change and reason for change:

4. 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

5. Is any Proposed Insured currently applying for other insurance coverage? ☐ Yes ☐ No

   If YES, please explain

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

   a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence *(DUI/DWI)*, or had more than 3 moving violations? ☐ Yes ☐ No

   If YES, please explain

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

   If YES, please explain

7. 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:

8. a. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No
   If YES, please provide details below.

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

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

9. **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. Has any Proposed Insured **ever** consulted with or been diagnosed, treated, hospitalized or prescribed medication by a licensed 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, thyroid, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? ☐ Yes ☐ No

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

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

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

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

   g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? ☐ Yes ☐ No

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

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

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

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

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

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

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

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

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

3. To the best of my knowledge and belief, has any Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death. ☐ Yes ☐ No

   _____

4. To the best of my knowledge and belief:

   a. Has any Proposed Insured **ever** been diagnosed by or received treatment from a licensed medical professional for any genital or reproductive organ disorder, miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No

   b. Has any Proposed Insured been diagnosed by a licensed medical professional as being pregnant? ☐ Yes ☐ No

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

   c. Is any Proposed Insured currently receiving treatment from a licensed medical professional for pregnancy? ☐ Yes ☐ No

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

   If YES, please list name(s) of Proposed Insured(s) _____

DETAILS: Enter complete details from questions #1-4 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 Benefit Rider

☐ Other Insured Term Insurance Benefit 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

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

☐ Return of Premium Benefit Rider

WHOLE LIFE INSURANCE

Face Amount $ _____

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

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

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

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

☐ Disability Waiver of Premium Benefit Rider

☐ 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

☐ 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 Rider *(VER)* ☐ Periodic Premiums $ _____ ☐ Single Premium $ _____

SINGLE PREMIUM WHOLE LIFE INSURANCE

Face Amount $ _____

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

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

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name *(First, Middle, Last)*				
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to Proposed Insured				

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

Has any proposed insured child ever had a licensed medical professional:

a. Make a diagnosis of or treat for internal cancer or tumor, lymphoma, leukemia, disorder of the lymph nodes or glandular disorder? ..... ☐ Yes ☐ No

b. Make a diagnosis of or treat for heart disease or disorder? ..... ☐ Yes ☐ No

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

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

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

If YES, please list type: _____ amount per day: _____ last date of use *(MM/DD/YYYY)* / /

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

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

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

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

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

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

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

Reason for consultation _____

Results _____

PHYSICIAN INFORMATION

Please list the last physician seen:

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

Address _____
Street Address Suite

_____
City State ZIP+4

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

Is this your primary physician? ☐ Yes ☐ No

Reason for consultation _____

Results _____

_____

AGREEMENT

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

I *(We)* agree that:

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

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

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

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

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

_____ _____
Agent No. Agent's Florida License No.

FIELD UNDERWRITER'S STATEMENT

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

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

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

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

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

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

   _____

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ☐ Yes ☐ No
   Agent is responsible for scheduling exam items.
   NOTE: ANY PREFERRED PLANS REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.
   ☐ Paramedical examination ☐ Blood Sample ☐ Urine Sample ☐ Electrocardiogram *(EKG)* ☐ Treadmill EKG ☐ Medical exam by physician

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

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

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

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

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

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

AUTOMATIC PAYMENT OPTIONS

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

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

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

LIST BILL

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

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

FOR TERM LIFE APPLICATION

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

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

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

Other Insured's underwriting classification _____

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

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

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

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

Other Insured's underwriting classification _____

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

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

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

Additional Insured's underwriting classification _____

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

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

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

_____ / / _____ ( ) / ( )

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

_____ _____ _____

Soliciting Agent's Printed Name/Agent No. *Florida License 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 redisclosed in accordance with other applicable laws or regulations.

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

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

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

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

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

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

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

ASSURITY LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • 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
1526 K Street, P.O. Box 82533, Lincoln, NE 68501
402.476.6500 · 800.276.7619 · FAX 402.437.4588

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

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

EXAMINER: _____
Name *Address*

CONSENT FOR HIV TESTING

To evaluate your insurability, the insurer named above *(the Insurer)* has requested that you provide a sample of your blood or other bodily fluids for testing and analysis to determine the presence of human immunodeficiency virus *(HIV)* antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test results. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

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

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS, but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. Results will be reported by the laboratory to the insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULT

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result _____

Physician's address _____
Street Address *City* *State* *Zip*

CONSENT

I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood form me, the testing of that blood, and the disclosure of the test results described above.

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

_____ _____
Signature of Proposed Insured or Legal Representative *Date Signed (MM/DD/YYYY)*

_____
Name of Proposed Insured (Printed)

_____
Address of Proposed Insured *City* *State* *Zip*

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Life Insurance
REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarized your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ Yes ☐ No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

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

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

_____
Agent's Address (Print) *Street Address* *City* *State* *Zip*

_____
Agent's Company (Print)

Information on policies which may be replaced:

COMPANY NAME	POLICY NO.	NAME OF INSURED

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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ACCELERATED BENEFITS RIDER DISCLOSURE STATEMENT

For use with: Term and Whole Life

BENEFITS PAID UNDER THIS RIDER MAY BE TAXABLE. 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 affect qualifications for entitlement payments.

DEFINITIONS

Eligible Proceeds means up to a total of $250,000 of the policy face amount.

Benefit Amount means the portion of the Eligible Proceeds you elect to receive, adjusted by a variety of factors including:

- expected future premiums;
- current dividends, if any; and
- 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 statutory adjustable policy loan interest rate.

We will also deduct a processing charge from the Benefit Amount. This charge will not exceed $100. We will tell you what the charge is when you request this rider's benefit.

Terminally Ill means having an expected life span of 12 months or less. You must provide us with a doctor's certification of the insured's life expectancy.

RIDER BENEFIT

Subject to rider conditions, you may request to receive the Benefit Amount while the insured is alive if the insured qualifies for the Terminal Illness Option. There are four types of rider conditions.

Conversion Conditions. These rider conditions concern which policies and riders you can convert to a Benefit Amount.

- You can combine all of your in-force life insurance coverage on the life of the insured from all policies and riders issued by Assurity.
- You cannot convert more than $250,000.

Election Conditions. These rider conditions tell you how to elect this rider's benefit.

- You must request the rider benefit in writing.
- You must send the request for the rider benefit to our administrative office.
- You must provide us with a physician's statement.

Voluntary Conditions. This rider's benefit is only available if you take it on your own policy. You cannot exercise this rider if you are required:

- by law to use this rider to pay creditors' claims; or
- by the government to use this rider to receive a government benefit.

General Conditions. You cannot elect this rider:

- during your policy's Contestable Period;
- within 2 years of your policy's final expiration date;
- if your policy is on extended term insurance; or
- if your policy is assigned or has an irrevocable beneficiary unless prior written acknowledgment to release is received by us.

Terminal Illness Options. This option lets you receive a Benefit Amount if the insured is Terminally Ill. If you do not want to receive the payment in a lump sum, you can be paid in 12 equal monthly payments. If you take 12 payments, we will pay interest of not less than 3 percent per year. If the insured dies before all 12 payments are made, we will pay the beneficiary the present value of future payments based on the monthly interest rate used to calculate the original payments.

EFFECT ON POLICY

Following the payment of the Benefit Amount, the policy will stay in force at a reduced amount. The reduction is the percentage of Eligible Proceeds used. For example, if you convert 25 percent of your policy's Eligible Proceeds, only 75 percent of the policy's face amount stays in force. The policy premium will be reduced to the premium that would apply had the policy been issued at the reduced amount. There will be no change in any policy or rider that was not part of the Eligible Proceeds. We will provide you with a revised policy schedule which reflects the reduction of all values applicable to the policy and all benefits the policy provides.

TERMINATION

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

- the date we approve your written request to accelerate benefits; or
- the date your policy terminates for any reason.

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

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

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

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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)