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

Application for SIMPLIFIED LIFE INSURANCE

PLEASE PRINT WITH 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.

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(s): | 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 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:

2. 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

3. 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 %**
			/ /	
			/ /	
			/ /	

4. SECONDARY ADDRESSEE

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

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

5. PREMIUM PAYMENT MODE

Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly *(Automatic)* ☐ List Bill

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

Billing Address (Street Address, City, State, ZIP+4) | Personal Phone No. ( )

6. GENERAL SECTION

1. In the past **2 years,** has the Proposed Insured been charged with or convicted of a felony? *(If YES, coverage cannot be issued.)* ..... ☐ Yes ☐ No
2. Is the Proposed Insured currently negotiating for other insurance coverage? ..... ☐ Yes ☐ No
3. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ..... ☐ Yes ☐ No
4. Does the Proposed Insured have other insurance coverage in force? ..... ☐ Yes ☐ No
   If YES, please provide details below, and complete and return the appropriate State Replacement Form.

   Name of the company _____ Policy No. _____

7. HEALTH SECTION

Section A—If any question is answered YES, coverage cannot be issued.

1. Has the Proposed Insured been medically diagnosed as having a life expectancy of **12 months** or less? ☐ Yes ☐ No

2. In the past **12 months,** has the Proposed Insured been medically diagnosed with diabetes or been treated by a licensed medical professional for uncontrolled diabetes or any complications thereof, including numbness, amputation, circulation, eye or kidney disorder, coma or insulin shock, needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing, dressing, grooming, walking, managing medications)*, had or been advised by a licensed medical professional to have brain, heart or circulatory surgery, been medically diagnosed as having chronic respiratory disease such as chronic obstructive pulmonary disease *(COPD)* or emphysema, been treated by a licensed medical professional with oxygen, been medically diagnosed with heart disease or myocardial infarction *(heart attack)* or heart-related chest pain *(angina)*, or been confined to a nursing facility or received inpatient services at a medical facility for more than 48 continuous hours? ☐ Yes ☐ No

3. Has the Proposed Insured **ever** been medically diagnosed as having or been treated for *(including office visits, medication or surgery)*: leukemia, Hodgkin's disease, a blood or bleeding disorder, connective tissue disorder, Parkinson's disease, systemic lupus erythematosus *(SLE)*, amyotrophic lateral sclerosis *(ALS)*, cirrhosis, chronic hepatitis B, C or D, liver disease, kidney disease with dialysis treatment, Alzheimer's disease, dementia, lymphoma, lymph node enlargement or malignant melanoma; or received or been advised by a licensed medical professional to receive an organ or tissue transplant; or in the past **5 years** been medically diagnosed with or been treated for internal cancer? ☐ Yes ☐ No

4. Has the Proposed Insured been medically diagnosed as having cerebral palsy, muscular dystrophy, cystic fibrosis, sickle cell anemia, Down's syndrome or congenital heart disease? ☐ Yes ☐ No

5. Has the Proposed Insured had a medical test and not yet received the results, or been advised by a licensed medical professional to have surgery or receive medical treatment? ☐ Yes ☐ No

6. Has the Proposed Insured **ever** been tested positive for 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

Section B—If this question is answered YES, the Proposed Insured will be considered for the Modified Benefit Whole Life coverage.

1. In the past **90 days,** has the Proposed Insured been, or are they now, confined to a psychiatric facility or receiving home health care? ☐ Yes ☐ No

Section C—Complete only if all answers in Sections A were NO. Any YES answers in Section C limit consideration to Graded Benefit Whole Life coverage.

1. In the past **12 months**, has the Proposed Insured been medically diagnosed as having or been treated by a licensed medical professional for: congestive heart failure or cardiomyopathy, stroke, aneurysm or sleep apnea, or had or been advised by a licensed medical professional to have treatment for any drug or alcohol abuse? ☐ Yes ☐ No

2. In the past **5 years**, has the Proposed Insured been medically diagnosed as having heart disease requiring bypass surgery, angioplasty or placement of stents or cardiac defibrillator? ☐ Yes ☐ No

3. Has the Proposed Insured **ever** been treated by a licensed medical professional for *(including office visits, medication or surgery)*: diabetes requiring insulin injections combined with a medical history of stroke, transient ischemic attack *(TIA)* or heart disease? ☐ Yes ☐ No

If all questions in Sections A, B and C are answered NO, the Proposed Insured will be considered for Level Benefit Whole Life coverage.

8. POLICY INFORMATION

Plan of Insurance: ☐ Level Benefit Whole Life ☐ Graded Benefit Whole Life ☐ Modified Benefit Whole Life Initial Death Benefit $ _____

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:

1. 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.
2. 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. 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.
3. 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 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 Owner(s) (If other than Proposed Insured)*

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

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 the Proposed Insured on the date of application? ☐ Yes ☐ No

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

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

If YES, please provide details _____

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

b. Does the Proposed Insured have other insurance coverage in force? ☐ Yes ☐ No

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

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—signed authorization and voided check attached with the application.

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

~~☐ Set up NEW credit card payment - signed authorization attached with the application.~~

LIST BILL

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

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

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	*Florida License No.*	*Agent's E-mail*
_____	___/___/___	_____ (___)
Signature of Second Soliciting Agent (if split commission)	*Date (MM/DD/YYYY)*	*Florida License No.* *Business Phone No.*

LEVEL BENEFIT WHOLE LIFE

	MALE		FEMALE			MALE		FEMALE			MALE		FEMALE	
Issue Age	NTob	Tob	NTob	Tob	Issue Age	NTob	Tob	NTob	Tob	Issue Age	NTob	Tob	NTob	Tob
0	6.95		5.44		27	14.96	16.53	13.65	15.20	54	35.06	42.69	29.88	37.53
1	7.22		5.72		28	15.11	17.04	13.76	15.61	55	36.46	44.56	30.88	38.83
2	7.55		6.03		29	15.30	17.56	13.92	16.04	56	37.91	46.57	31.92	40.17
3	7.90		6.35		30	15.56	18.08	14.13	16.47	57	39.39	48.69	32.99	41.53
4	8.29		6.68		31	15.90	18.59	14.41	16.90	58	40.98	50.99	34.14	42.98
5	8.69		7.03		32	16.30	19.10	14.75	17.34	59	42.77	53.57	35.45	44.59
6	9.11		7.39		33	16.74	19.63	15.12	17.81	60	44.83	56.49	36.98	46.45
7	9.54		7.77		34	17.22	20.20	15.53	18.31	61	47.13	59.71	38.75	48.56
8	10.00		8.15		35	17.73	20.82	15.96	18.86	62	49.61	63.17	40.71	50.89
9	10.47		8.55		36	18.25	21.49	16.40	19.44	63	52.33	66.96	42.84	53.40
10	10.95		8.96		37	18.80	22.19	16.84	20.05	64	55.35	71.16	45.12	56.05
11	11.46		9.25		38	19.38	22.95	17.33	20.71	65	58.72	75.84	47.53	58.82
12	11.98		9.50		39	20.02	23.76	17.87	21.44	66	62.42	80.94	49.97	61.63
13	12.48		9.73		40	20.73	24.66	18.48	22.26	67	66.41	86.40	52.46	64.49
14	12.67		9.96		41	21.53	25.65	19.20	23.20	68	70.73	92.33	55.14	67.53
15	12.85	14.38	10.19	13.24	42	22.41	26.72	20.00	24.26	69	75.42	98.84	58.14	70.87
16	13.03	14.51	10.42	13.37	43	23.33	27.86	20.85	25.37	70	80.51	106.04	61.60	74.63
17	13.21	14.64	10.65	13.51	44	24.29	29.03	21.71	26.50	71	85.65	113.52	65.37	78.50
18	13.40	14.77	10.87	13.64	45	25.25	30.22	22.54	27.60	72	90.83	121.20	69.35	82.40
19	13.58	14.90	11.12	13.77	46	26.20	31.42	23.32	28.66	73	96.55	129.71	73.78	86.80
20	13.76	15.03	11.42	13.90	47	27.16	32.63	24.09	29.71	74	103.36	139.66	78.88	92.17
21	13.94	15.15	12.01	14.01	48	28.14	33.89	24.86	30.76	75	111.76	151.67	84.88	98.99
22	14.12	15.28	12.63	14.10	49	29.16	35.20	25.65	31.83	76	121.70	165.61	91.75	107.27
23	14.30	15.41	13.14	14.20	50	30.25	36.59	26.46	32.93	77	132.84	181.07	99.35	116.68
24	14.48	15.54	13.28	14.34	51	31.38	38.02	27.29	34.05	78	145.25	198.24	107.70	127.23
25	14.66	15.67	13.42	14.55	52	32.54	39.47	28.11	35.17	79	159.04	217.34	116.88	138.90
26	14.82	16.07	13.54	14.85	53	33.76	41.01	28.97	36.32	80	174.28	238.57	126.92	151.69

GRADED BENEFIT and MODIFIED BENEFIT WHOLE LIFE

	MALE		FEMALE			MALE		FEMALE	
Issue Age	NTob	Tob	NTob	Tob	Issue Age	NTob	Tob	NTob	Tob
40	31.31	39.02	28.13	35.07	61	70.77	97.10	57.94	77.68
41	32.60	40.74	29.37	36.88	62	74.14	102.49	60.30	80.70
42	33.92	42.53	30.61	38.68	63	77.82	108.36	62.87	84.00
43	35.27	44.37	31.84	40.49	64	81.95	114.82	65.69	87.70
44	36.66	46.27	33.06	42.29	65	86.65	121.95	68.84	91.95
45	38.08	48.23	34.27	44.10	66	91.81	129.50	72.17	96.71
46	39.51	50.21	35.46	45.89	67	97.35	137.41	75.64	101.89
47	40.95	52.22	36.61	47.65	68	103.43	146.06	79.47	107.54
48	42.43	54.31	37.77	49.43	69	110.20	155.84	83.86	113.69
49	44.00	56.52	38.96	51.25	70	117.82	167.15	89.04	120.40
50	45.68	58.93	40.20	53.14	71	125.89	179.54	94.73	127.22
51	47.49	61.52	41.48	55.12	72	134.29	192.76	100.79	134.13
52	49.39	64.25	42.77	57.16	73	143.65	207.46	107.62	141.77
53	51.38	67.13	44.11	59.25	74	154.54	224.31	115.64	150.81
54	53.46	70.18	45.51	61.37	75	167.58	243.97	125.25	161.91
55	55.62	73.41	47.01	63.53	76	182.62	266.18	136.37	175.04
56	57.77	76.70	48.56	65.64	77	199.28	290.48	148.73	189.77
57	59.93	80.04	50.14	67.70	78	217.74	317.29	162.44	206.12
58	62.21	83.61	51.82	69.83	79	238.21	347.01	177.65	224.13
59	64.73	87.57	53.66	72.16	80	260.90	380.02	194.47	243.80
60	67.61	92.09	55.71	74.81					

SAMPLE PREMIUM CALCULATION	
Annual Premium per $1,000	= 58.72
Annual Premium = $58.72 x 10 (# of $1000s)	= $587.20
+ Policy Fee	= $25.00
Total Annual Premium	= $612.20
Semi-annual Premium $612.20 x .51	= $312.22
Quarterly Premium: $612.20 x .264	= $161.62
Monthly Bank Draft: $612.20 x .088	= $53.87

All rates in U.S. Dollars.

Annual Premiums per $1,000 of Face Amount.

Policy Fee: $25.00

ASSURITY® LIFE INSURANCE COMPANY
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(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

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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)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

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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 402.437.4591

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.

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

Automatic PREMIUM PAYMENT

PLEASE PRINT WITH BLACK INK

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

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

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

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

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

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

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

Type of Account: ☐ Checking ☐ Savings

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

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

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

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

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

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

Customer Identification INFORMATION

PLEASE PRINT WITH BLACK INK

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

Legal name of Policyowner _____ **Social Security number** _____

Policyowner's occupation _____

1. Source of funds

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

_____

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

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

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

3. Intended purpose of coverage applied for

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

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

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

5. Agent/Policyowner relationship

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

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

_____

_____

7. The information on this form was obtained from

Name _____

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

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

_____ _____
Producer Signature *Producer No.*

_____ _____
Producer Name (printed) *Date (MM/DD/YYYY)*

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