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

# Simplified Critical Illness

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:

- AR, CO, FL, GA, ID, IL, ME, MN, MT, NH, NC, ND, OK, PA, SD, TX, UT and WV

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
# Application for Critical Illness Insurance

I hereby apply for insurance with Assurity Life Insurance Company.

## A. Proposed Insured

| 1. Name | 2. Sex ☐M ☐F | 3.a. Date of Birth<br>b. Birth State | 4. Age |
|---|---|---|---|
| 5. Address | | 6. Social Security Number | |
| 6. City, State, ZIP | | 7. Telephone (Area Code/Number) | |
| 8. Height | 9. Weight | 10. Best Time to Call | |

11. U.S. Citizen? ☐ Yes ☐ No If No, how long has he or she been in the U.S.? _____
If not a citizen, does he or she have a permanent visa? ☐ Yes ☐ No If Yes, please provide a copy.

12. Employer _____ Occupation _____

Duties _____

13. Plan: **Critical Illness**

Benefit Amount:

$_____

Premium Payment Method:

☐ Annually ☐ Quarterly
☐ Semi-Annually ☐ Monthly
☐ Other _____

Amount Collected:

$_____

14. Rider(s)
- ☐ Accidental Death Benefit $_____
- ☐ Children's Rider ☐ $5,000 ☐ $10,000
- ☐ Return of Premium
- ☐ Spouse Rider Benefit Amount $_____
- ☐ Waiver of Premium

15. Name of spouse and/or dependent children (who have not reached their 19th birthday) proposed for coverage under the Spouse and/or Children's Rider.

| Full Name | Relationship | Sex M/F | Date of Birth | Age | Height | Weight | Residing with Proposed Insured Yes | No |
|---|---|---|---|---|---|---|---|---|
| | Spouse | ☐ ☐ | | | | | ☐ | ☐ |
| | Child | ☐ ☐ | | | | | ☐ | ☐ |
| | Child | ☐ ☐ | | | | | ☐ | ☐ |
| | Child | ☐ ☐ | | | | | ☐ | ☐ |

16. Beneficiary Name Relationship SS#/TIN Date of Birth/Trust

Primary: _____

Contingent: _____

## B. Answer the Following Questions:

| | YES | NO |
|---|---|---|
| 1. Does the Proposed Insured(s) have any other Critical Illness (lump sum diagnostic benefits) coverage in force and applied for? If **Yes,** list company name and amount. _____ | ☐ | ☐ |
| 2. If under age 65, is the Proposed Insured(s) receiving Medicare or Medicaid? | ☐ | ☐ |
| 3. Has the Proposed Insured(s) been postponed or declined Critical Illness coverage? | ☐ | ☐ |
| 4. Has there been, or will there be, a lapse, surrender, loan, or other change to any existing health insurance as a result of, or in anticipation of, this application? | ☐ | ☐ |

If **Yes,** name of person(s)_____

If **Yes,** name of person(s)_____

5. Estimated Annual Income $_____ Sources: _____

## C. Health History (Questions 1 through 6 apply to all Proposed Insured(s)):

| | YES | NO |
|---|---|---|
| 1. During the past two years, has the Proposed Insured(s) received medical care from a member of the medical profession for, or experienced symptoms of, any of the following? If Yes, indicate all that apply. | ☐ | ☐ |
| 2. Has the Proposed Insured(s) ever received medical care from a member of the medical profession for, or been diagnosed with, any of the following? If Yes, indicate all that apply. | ☐ | ☐ |
| 3. Has the Proposed Insured(s) tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any AIDS related condition? | ☐ | ☐ |
| 4. Does the Proposed Insured(s) intend to live or travel outside the United States or Canada for more than two months during the next 24 months? | ☐ | ☐ |
| 5. During the past two years has the Proposed Insured(s) been advised by a member of the medical profession: a) of any abnormal diagnostic test results or been advised to have any diagnostic tests (includes self-administered) which have not yet been completed? | ☐ | ☐ |
| b) to undergo any treatment, hospitalization or surgery which has not yet been completed? | ☐ | ☐ |
| 6. During the past five years, has the Proposed Insured been unable to perform any of the following activities on his/her own: transferring in or out of a chair or bed, dressing, bathing, feeding, toileting or continence? | ☐ | ☐ |
| 7. Have any **two or more** of the Proposed Insured's natural parents, brothers or sisters, either living or deceased, been diagnosed with the **same condition(s)** from the following list: | | |
| • Heart disease, stroke, diabetes, kidney disease or breast cancer prior to age 60? | ☐ | ☐ |
| • Colorectal cancer or Alzheimer's or Senile Dementia prior to age 75? | ☐ | ☐ |
| • Any other same cancer in both relatives prior to age 55? | ☐ | ☐ |
| 8. Has the Proposed Insured(s) used any tobacco or nicotine product during the past 12 months? | ☐ | ☐ |

☐ Disorder of the heart or circulatory system
☐ Unexplained Weight Loss
☐ Fibrocystic breast disease, recurrent breast tumors, or unexplained tumors/growths
☐ Unexplained Fatigue
☐ Unexplained Dizziness
☐ Abnormal Pap Smear

☐ Stroke (including Transient Ischemic Attack)
☐ Heart Attack
☐ Alcoholism
☐ Drug Abuse
☐ Cancer (other than skin cancer)
☐ Melanoma
☐ Abnormal Kidney Functions
☐ Recurrent Human Papilloma virus (HPV) or Sexually Transmitted Disease (within the past 5 years)
☐ Diabetes
☐ Hepatitis B or C
☐ Chronic Lung Disease
☐ Cirrhosis
☐ Skin Cancer (2 or more occurrences)
☐ Ulcerative Colitis
☐ Crohn's Disease
☐ Alzheimer's or Senile Dementia
☐ Systolic Blood Pressure 150 or greater within the last 6 months
☐ Diastolic Blood Pressure 95 or greater within the last 6 months

If any question in this section (Section C, Questions 1 – 5) is answered "Yes", list the name(s) of the person(s).

_____

## D. AGREEMENT

**I HEREBY AGREE THAT:** 1. All answers in this Application : (a) are true and complete to the best of my knowledge; and (b) will be relied on to determine insurability. 2. If the minimum premium deposit is paid on the date this Application is signed, the policy applied for will be in effect from that date, subject to: (a) underwriting requirements; (b) the terms of the attached Conditional Receipt; (c) the terms of the policy and (d) the issuing Company's right to rescind the policy. The minimum premium deposit is the amount equal to the full premium for the mode chosen on this application for the policy applied for. 3. If the minimum premium deposit is not paid as provided in "2 (b)" above, then no insurance will be in effect unless: (a) during the lifetime of the Proposed Insured, a policy is delivered to the Proposed Insured/Owner and accepted and the entire first premium is paid; and (b) at the time of delivery or acceptance or payment, whichever is later, all answers in this Application are still true and complete to the best of my knowledge. 4. No agent is authorized to waive the terms of this Agreement.

**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.**

Dated at _____ this _____ day of _____ , _____
City State Day Month Year

_____ Witnessed by _____
(Signature of Proposed Insured) (Licensed Resident Agent)

_____ Assurity Agent Number _____
(Signature of Spouse)

Florida License ID No. _____

## FIELD UNDERWRITER'S STATEMENT

1. What amount was collected with this application? $_____
2. Has a Conditional Receipt been given to the Proposed Insured?..... ☐Yes ☐No
3. Did you personally see the Proposed Insured/Owner on date of application? (If "No," please explain in #6)..... ☐Yes ☐No
4. Is the Proposed Insured/Owner a citizen of the United States?..... ☐ Yes ☐No
   If "No," provide a copy of their permanent visa.
5. If this insurance is issued, will it replace any insurance, annuity, or other policy? (If "Yes," please explain in #6.) ..... ☐ Yes ☐No
6. Special Requests, Remarks, and Instructions: _____

Was this application faxed? ( ) Y ( ) N
If "yes", give date.
_____

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.

_____ _____ _____
Soliciting Agent Signature Code Number Date

_____ _____ _____
Soliciting Agent Printed Name Agent Phone Number Agent Fax Number and/or Email Address

## Automatic Bank Withdrawal

Automatic Bank Withdrawal conveniently pays your monthly premium from your checking account – saving you time and money. To begin this convenient service, please complete the form below and return it to us with a voided check. Remember to indicate the date of withdrawal that would be most convenient for you.



I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. 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.

Date of Withdrawal: _____ (cannot be the 29th, 30th or 31st; IF NO DATE IS ENTERED, THE POLICY ISSUE DATE WILL BE USED.)

Draft initial premium payment: ☐ Yes ☐ No FIRST PREMIUM FOR THIS INSURANCE WILL BE DEBITED FROM YOUR ACCOUNT AT THE TIME THE POLICY IS ISSUED.

**DO NOT SIGN**

| Signature of Account Holder | Telephone Number | Date Signed |
|---|---|---|

### Credit Card Authorization



I authorize Assurity Life Insurance Company to charge the credit card listed below in the amount of $_____ for the first premium on the policy or policies for which I am applying. In this date, I acknowledge I) the use of the credit card for payments is optional: 2) this authorization does not cover the charging of future premiums, 3) coverage under the policy begins only as specified in the Conditional Receipt I have received; 4) my account will be credited if I make use of the Policy's Right to Cancel provision; and 5) this charge will be initiated only when the accompanying application is accepted.

| Name on Card | Card/Account Number | Expiration Date | Date of Signature |
|---|---|---|---|

**DO NOT SIGN**

☐ Mastercard ☐ Visa ☐ Discover

Signature of Card Holder

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## CONDITIONAL RECEIPT

**Assurity Life Insurance Company**
1526 K Street, P.O. Box 82533
Lincoln, Nebraska 68501-2533
Toll Free 1-800-276-7619

Make **all** premium checks payable to Assurity Life Insurance Company. Please **do not** make checks payable to the agent or leave "payee" blank.

Received from_____ with the attached Application to Assurity Life Insurance Company the sum of $ _____as payment of the first premium for the critical illness insurance applied for

a. If the first premium acknowledged by this Conditional Receipt is paid on or before the date the Application was signed; and
b. If, on the date the Application was signed, the Proposed Insured was insurable without special exception and at standard rates under the Company's underwriting rules and practices for the insurance applied for;

the Company agrees to insure the Proposed Insured(s) under this Conditional Receipt. The amount of insurance hereunder will be the lesser of the amount applied for, or the amount for which the Proposed Insured qualifies, but not to exceed $50,000 for any individual applying for critical illness insurance with the Company.

This Conditional Receipt terminates the earlier of a) 60 days after the date the Application was signed, or b) the date the insurance applied for becomes effective. If one or more of the conditions are not met, the Company's liability will be limited to the return of the sum received. This Conditional Receipt is controlled by the terms of the policy applied for. No agent is authorized to change or alter this Conditional Receipt.

| Date | Agent |
|---|---|

**ASSURITY® LIFE INSURANCE COMPANY**
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • www.assurity.com

# Confidential Information Authorization

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

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

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

| *Legal Name* | ***Date of Birth*** | *Legal Name* | ***Date of Birth*** |
|---|---|---|---|
| | | | |
| | | | |

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

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

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

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

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

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

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

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

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

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

**ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT**

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

# Confidential Information Authorization

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

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

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

| *Legal Name* | ***Date of Birth*** | *Legal Name* | ***Date of Birth*** |
|---|---|---|---|
| | | | |
| | | | |

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

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

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

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

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

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

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

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

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

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

# Confidential Information Authorization for Release of Psychotherapy Notes

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

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

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

| *Legal Name* | ***Date of Birth*** | *Legal Name* | ***Date of Birth*** |
|---|---|---|---|
| | | | |
| | | | |

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

- Psychotherapy notes

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

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

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

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

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

# Confidential Information Authorization for Release of Psychotherapy Notes

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

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

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

| *Legal Name* | ***Date of Birth*** | *Legal Name* | ***Date of Birth*** |
|---|---|---|---|
| | | | |
| | | | |

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

- Psychotherapy notes

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

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

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

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

**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 (888) 255-2060

# CONSUMER NOTICE

## MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Assurity or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 *(TTY 866-346-3642)*. If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

## Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, Assurity will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices, please direct your requests to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

## Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended *(15 U.S.C. 1681d)*, notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, Assurity Life Insurance Company *(Assurity)* may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation Assurity requests. Please direct this written request to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Upon receipt of such a request, Assurity will respond by mail within five business days.

## Telephone Interview Information

Assurity may require that you complete a confidential telephone interview as a part of your application for insurance. The interview will be conducted by a trained professional and may include *(but is not limited to)* the following topics: occupation, job history, income, personal and business financial information and medical history. All information obtained will be used for underwriting purposes only and will not be released without your written consent.

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

# Temporary Conditional Insurance Agreement

*(for use with 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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- 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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**Accident or Sickness Insurance**
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**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)*