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 <u>age last birthday</u> 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 <u>all other</u> 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 B b. Birth Stat		4. Age
5. Address 6. Social Security Number					
6. City, State, ZIP 7. Telephone (umber)
8. Height	9. Weight		10. Best Time to Call		
11. U.S. Citizen? Yes No If No, ho If not a citizen, does he or she have a perm	w long has he or she been anent visa? ☐ Yes [en in the U.S No If Ye	.? es, please prov	ide a copy.	
12. Employer		_ Occupation	າ		
Duties					
13. Plan: Critical Illness	Benefit Amount:		ider(s) Accidental D	eath Benefit	
	\$	[☐ Children's Ri		
Premium Payment Method:	Amount Collected:		Spouse Ride		
☐ Annually ☐ Quarterly \$ ☐ Semi-Annually ☐ Monthly ☐ Other			Benefit Amo	ount \$	
15. Name of spouse and/or dependent children Spouse and/or Children's Rider.	(who have not reached their	19 th birthday)	proposed for o	coverage unde	r the
Se Full Name Relationship M/		ie Height	: Weight	Residing w Proposed Ins Yes	
Spouse				.	
Child				. 🗆 [
Child				. 🗆 [
Child					
16. Beneficiary Name	Relationship	SS	#/TIN	Date of Bir	th/Trust
Primary:					
Contingent:					

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.	NO
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?	
5.	Estimated Annual Income \$ Sources:	
C.	Health History (Questions 1 through 6 apply to all Proposed Insured(s)): YES	NO
1.		
2.	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?	
	If any question in this section (Section C, Questions 1 – 5) is answered "Yes", list the name(s) of the person(s).	
8.	Has the Proposed Insured(s) used any tobacco or nicotine product during the past 12 months?	

D. AGREEMENT

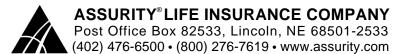
I HEREBY AGREE THAT: 1. All answers in this Application: (a) are true and complete to the best of my knowledge; and (b) will be relied on to determine insurability. 2. If the minimum premium deposit is paid on the date this Application is signed, the policy applied for will be in effect from that date, 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.

Da	ted atCity	th	is	day of			
	City	State	Day	,	Month	Yea	ır
				Witnessed by	/		
	(Signature of Prop	osed Insured)			(Licensed Re	esident Agent)	
				Assurity Age	nt Number		
	(Signature of	Spouse)		Florida Licen	se ID No		
		FIELD UND	ERWRITE	R'S STATE	MENT		
1.	What amount was collected	with this applicatior	າ? \$				
2.	Has a Conditional Receipt be	een given to the Pr	oposed Insu	ıred?		Yes	□No
3.	Did you personally see the F in #6)						□No
4.	Is the Proposed Insured/Owl If "No," provide a copy of the		United State	es?		Yes [□No
5.	If this insurance is issued, w explain in #6.)						∐No
6.	Special Requests, Remarks,	and Instructions: _				Was this applica faxed? () Y (If "yes", give dat) N
	ereby certify that to the best o d correct.	f my knowledge an	d belief, the	answers on the	e application and in thi	s statement are tr	rue
	Soliciting Agen	t Signature		Code	Number	Date	
	Soliciting Agent Printed	Name	Agent Pho	one Number	Agent Fax Number	and/or Email Ado	dress

Automatic Bank Withdrawal

convenient service, please comple be most convenient for you.	eniently pays your monthly premium from ete the form below and return it to us with	n a voided check . Remembe	er to indicate th	he date of withdrawal that would	
Assurity Life Insurance Company	k fritt hife Insurance Company, Lincoln, l t until ewoksd to n e in the manner provi shall be fully precede lijn von Virio a v d	ebit to my account.	notice of such	revocation, I agree that	
Date of Withdrawal: (ca	nnot be the 29th, 30th or 31st; IF NO DA	FEILENTER ENTERPOLI	CY ISSUE DA	ATE WILL BE USED.)	
Draft initial premium payment:	nnot be the 29th, 30th or 31st; IF NO DA Yes No FIRST PREMIUM FOR THE TIME THE POLICE	R THIS INSURANCE WILL E CY IS ISSUED.	se debkér)	ROMY OUR ACCOUNT AT	
DO NOT SIGN				05055	
Signature of Account Holder		Telephone Number		Date Signed	
I authorize Assuri V is in turance or policies for which I am applying cover the charging of future premi account will be credited if I make application is accepted.	Credit Card Company to charge the credit card listed In this date of acknowledge I) the use of It is pelicy begins Use of the Policy's Right to Cance of plays Card/Account Number	Authorization d below in the amount of \$ the credit card for payments s only as specified in the Cor ion; and 5) this charge will be ACED WITH	for s is optional: anditional Rece e initiated only	the first premium on the policy 2) this authorization does not ipt I have received; 4) my when the accompanying	
Name on Card	Card/Account Number	Expiration Date	· Offil	1 75-050-05055	
		Mastercard	□Visa	☐ Discover	
Signature of Card Holder					
Make all premium checks the agent or leave "payee	Lincoln, Nebras Toll Free 1-8 payable to Assurity Life Insura		e do not m	ake checks payable to	
Received from		with the attached	Application	n to Assurity Life	
Insurance Company the sillness insurance applied		as payment of the	first prem	ium for the critical	
Application was sign. b. If, on the date the A	acknowledged by this Conditions of the Conditions of the Properties of the Properties of the Company of the Com	oposed Insured was in	nsurable w	rithout special	
insurance hereunder will	nsure the Proposed Insured(s) be the lesser of the amount aped \$50,000 for any individual a	plied for, or the amou	int for whic	the Proposed Insured	
date the insurance applie liability will be limited to the	terminates the earlier of a) 60 d for becomes effective. If one ne return of the sum received. agent is authorized to change	or more of the condit This Conditional Rece	tions are ne eipt is cont	ot met, the Company's rolled by the terms of	
D	ate		Ager	nt	



Confidential Information Authorization

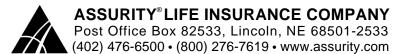
			1 1
Legal Name of	Applicant/Insured/Claimant (Please p	rint)	Date of Birth (MM/DD/YYYY)
Legal Name of Addi	tional Applicant/Insured/Claimant (Ple	ase print)	Date of Birth (MM/DD/YYYY)
Applicant/Insured/Claimant: List chil	ld(ren) and date(s) of birth		
Legal Name	Date of Birth	Legal Name	Date of Birth
		-	
I, on behalf of myself or the person na other medical or medically related facility institution or person, that has any rec reinsurers, any such information. This m	y, insurance company, MIB Inc. <i>(fort</i> ords or knowledge of me or my h	merly known as the Medical Informati	on Bureau), or other organization,
prescription drug records, or treat		to medical history, mental or phys mode of living (<i>except as may be rela</i> s.	
g .	-	y virus (HIV) infection and sexually tra	
are medication prescription and m	nonitoring, counseling sessions (start	use, and mental illness. Excluded are and stop times), the modalities and f sis, functional status, treatment plan, s	requencies of treatment furnished,
eligibility for insurance, including	additional coverage to an existing ling but not limited to information on	credit information. The records obt policy. I authorize the release of ar motor vehicle accidents and/or violated	ny information contained in credit
I understand that this information may be insurance companies with which the Indiv may be submitted. By this authorization, I	vidual has policies or to whom application	ations may be made, or to whom clair	ns for benefits have been made or
By my signature below, I acknowledge this authorization, and I instruct any lic custodians, other medical or medically employer or other organization or personal individual's entire medical record as desfor insurance, including additional coveribe subject to redisclosure by Assurity a information may only be redisclosed in a	censed physician, medical practition related facility, insurance or reinsur son that has any records or know scribed above without restriction. The age to an existing policy and/or eligitation may no longer be protected by the service of the serv	ner, hospital, clinic, pharmacy or pharance company, MIB Inc., consumer vledge of the Individual or their head ne medical information so acquired wibility for benefits under a policy. I under federal rules governing privacy of the federal rules governing privacy of the federal rules.	armacy benefit manager, records reporting agency, clearinghouse, alth, to release and disclose the vill be used to determine eligibility derstand that this information may
I further agree to execute additional docu application for insurance or claim for bene			
This authorization is valid for twenty-four (180 days from the date of the signature or claim. A copy of this authorization is authorization if requested. I understand the that a revocation is not effective to the exauthorization, Assurity may not be able to	e below), for collecting information in a s as valid as the original. I understanat I have the right to revoke this auth tent that action has been taken in reli	connection with an application for an ing and that I, or my authorized represer norization at any time by providing writ iance on this authorization. I further un	surance policy, policy reinstatement ntative, will receive a copy of this ten notice to Assurity. I understand derstand that if I refuse to sign this
This authorization complies with the	Health Insurance Portability and A	Accountability Act (HIPAA) Privacy	Rule.
1 1			
Date (MM/DD/YYYY)	Signature of Applicant/Insured	d/Claimant, Legal Representative or Pa	rent of Child(ren) under age 18
Signature of Additional Applicant/Insured	VClaimant or Legal Representative	Signature of Applicant/Insured/C	laimant 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

75-500-05055 (R11-12) [FR.11.28.12]





Confidential Information Authorization

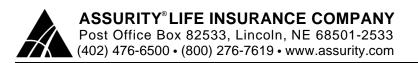
			1 1
Legal Name of	Applicant/Insured/Claimant (Please p	rint)	Date of Birth (MM/DD/YYYY)
Legal Name of Addi	tional Applicant/Insured/Claimant (Ple	ase print)	Date of Birth (MM/DD/YYYY)
Applicant/Insured/Claimant: List chil	ld(ren) and date(s) of birth		
Legal Name	Date of Birth	Legal Name	Date of Birth
		-	
I, on behalf of myself or the person na other medical or medically related facility institution or person, that has any rec reinsurers, any such information. This m	y, insurance company, MIB Inc. <i>(fort</i> ords or knowledge of me or my h	merly known as the Medical Informati	on Bureau), or other organization,
prescription drug records, or treat		to medical history, mental or phys mode of living (<i>except as may be rela</i> s.	
g .	-	y virus (HIV) infection and sexually tra	
are medication prescription and m	nonitoring, counseling sessions (start	use, and mental illness. Excluded are and stop times), the modalities and f sis, functional status, treatment plan, s	requencies of treatment furnished,
eligibility for insurance, including	additional coverage to an existing ling but not limited to information on	credit information. The records obt policy. I authorize the release of ar motor vehicle accidents and/or violated	ny information contained in credit
I understand that this information may be insurance companies with which the Indiv may be submitted. By this authorization, I	vidual has policies or to whom application	ations may be made, or to whom clair	ns for benefits have been made or
By my signature below, I acknowledge this authorization, and I instruct any lic custodians, other medical or medically employer or other organization or personal individual's entire medical record as desfor insurance, including additional coveribe subject to redisclosure by Assurity a information may only be redisclosed in a	censed physician, medical practition related facility, insurance or reinsur son that has any records or know scribed above without restriction. The age to an existing policy and/or eligitation may no longer be protected by the service of the serv	ner, hospital, clinic, pharmacy or pharance company, MIB Inc., consumer vledge of the Individual or their head ne medical information so acquired wibility for benefits under a policy. I under federal rules governing privacy of the federal rules governing privacy of the federal rules.	armacy benefit manager, records reporting agency, clearinghouse, alth, to release and disclose the vill be used to determine eligibility derstand that this information may
I further agree to execute additional docu application for insurance or claim for bene			
This authorization is valid for twenty-four (180 days from the date of the signature or claim. A copy of this authorization is authorization if requested. I understand the that a revocation is not effective to the exauthorization, Assurity may not be able to	e below), for collecting information in a s as valid as the original. I understanat I have the right to revoke this auth tent that action has been taken in reli	connection with an application for an ing and that I, or my authorized represer norization at any time by providing writ iance on this authorization. I further un	surance policy, policy reinstatement ntative, will receive a copy of this ten notice to Assurity. I understand derstand that if I refuse to sign this
This authorization complies with the	Health Insurance Portability and A	Accountability Act (HIPAA) Privacy	Rule.
1 1			
Date (MM/DD/YYYY)	Signature of Applicant/Insured	d/Claimant, Legal Representative or Pa	rent of Child(ren) under age 18
Signature of Additional Applicant/Insured	VClaimant or Legal Representative	Signature of Applicant/Insured/C	laimant 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

75-500-05055 (R11-12) [FR.11.28.12]



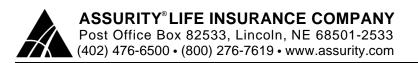


Confidential Information Authorization for Release of Psychotherapy Notes

			1 1
Legal Name o	Date of Birth (MM/DD/YYYY)		
Legal Name of Add	itional Applicant/Insured/Claimant (Ple	ase print)	Date of Birth (MM/DD/YYYY)
Applicant/Insured/Claimant: List ch Legal Name	ild(ren) and date(s) of birth Date of Birth	Legal Name	Date of Birth
	<u> </u>		
 I, on behalf of myself or the person national or medically related facilities institution or person, that has any recreinsurers, any such information. This representation is a Psychotherapy notes 	y, insurance company, MIB Inc. <i>(for</i> cords or knowledge of me or my h	merly known as the Medical Informat	tion Bureau), or other organization,
I understand that this information may be insurance companies with which the Ind may be submitted. By this authorization,	vidual has policies or to whom applic	ations may be made, or to whom clai	ims for benefits have been made or
By my signature below, I acknowledge this authorization, and I instruct any li custodians, other medical or medically employer or other organization or per Individual's entire medical record as defor insurance, including additional cove be subject to redisclosure by Assurity a information may only be redisclosed in	censed physician, medical practition related facility, insurance or reinsuration that has any records or know escribed above without restriction. The rage to an existing policy and/or eliginand may no longer be protected by	ner, hospital, clinic, pharmacy or pharmacy or pharmacy company, MIB Inc., consumentally ledge of the Individual or their hew he medical information so acquired vibility for benefits under a policy. I unthe federal rules governing privacy of	narmacy benefit manager, records r reporting agency, clearinghouse, ralth, to release and disclose the will be used to determine eligibility derstand that this information may
I further agree to execute additional doc application for insurance or claim for ber			
This authorization is valid for twelve (12 insurance policy, policy reinstatement representative, will receive a copy of the providing written notice to Assurity. I ur authorization. I further understand that been issued, may not be able to make a	or claim. A copy of this authorization is authorization if requested. I under iderstand that a revocation is not ϵ tif I refuse to sign this authorization,	on is as valid as the original. I un rstand that I have the right to revokeffective to the extent that action have	derstand that I, or my authorized e this authorization at any time by as been taken in reliance on this
This authorization complies with the	Health Insurance Portability and A	Accountability Act (HIPAA) Privacy	/ Rule.
1 1			
/ Date (MM/DD/YYYY)	Signature of Applicant/Insured	d/Claimant, Legal Representative or Pa	arent of Child(ren) under age 18
Signature of Additional Applicant/Insure	d/Claimant or Legal Representative	Signature of Applicant/Insured/C	Claimant Child (if age 18 or older)
Description of Legal Repres	entative's Authority for Applicant/Insur	red/Claimant (please indicate which Inc	dividual is represented)
,	, - , - , - , - , - , - , - , - , - , -	u ·	,,
Ol	RIGINAL TO HOME OFFICE, COPY	TO BE LEFT WITH APPLICANT	

75-502-05055 (R11-12) [FR.11.28.12]





Confidential Information Authorization for Release of Psychotherapy Notes

			1 1
Legal Name o	Date of Birth (MM/DD/YYYY)		
Legal Name of Add	itional Applicant/Insured/Claimant (Ple	ase print)	Date of Birth (MM/DD/YYYY)
Applicant/Insured/Claimant: List ch Legal Name	ild(ren) and date(s) of birth Date of Birth	Legal Name	Date of Birth
	<u> </u>		
 I, on behalf of myself or the person national or medically related facilities institution or person, that has any recreinsurers, any such information. This representation is a Psychotherapy notes 	y, insurance company, MIB Inc. <i>(for</i> cords or knowledge of me or my h	merly known as the Medical Informat	tion Bureau), or other organization,
I understand that this information may be insurance companies with which the Ind may be submitted. By this authorization,	vidual has policies or to whom applic	ations may be made, or to whom clai	ims for benefits have been made or
By my signature below, I acknowledge this authorization, and I instruct any li custodians, other medical or medically employer or other organization or per Individual's entire medical record as defor insurance, including additional cove be subject to redisclosure by Assurity a information may only be redisclosed in	censed physician, medical practition related facility, insurance or reinsuration that has any records or know escribed above without restriction. The rage to an existing policy and/or eliginand may no longer be protected by	ner, hospital, clinic, pharmacy or pharmacy or pharmacy company, MIB Inc., consumentally ledge of the Individual or their hew he medical information so acquired vibility for benefits under a policy. I unthe federal rules governing privacy of	narmacy benefit manager, records r reporting agency, clearinghouse, ralth, to release and disclose the will be used to determine eligibility derstand that this information may
I further agree to execute additional doc application for insurance or claim for ber			
This authorization is valid for twelve (12 insurance policy, policy reinstatement representative, will receive a copy of the providing written notice to Assurity. I ur authorization. I further understand that been issued, may not be able to make a	or claim. A copy of this authorization is authorization if requested. I under iderstand that a revocation is not ϵ tif I refuse to sign this authorization,	on is as valid as the original. I un rstand that I have the right to revokeffective to the extent that action have	derstand that I, or my authorized e this authorization at any time by as been taken in reliance on this
This authorization complies with the	Health Insurance Portability and A	Accountability Act (HIPAA) Privacy	/ Rule.
1 1			
/ Date (MM/DD/YYYY)	Signature of Applicant/Insured	d/Claimant, Legal Representative or Pa	arent of Child(ren) under age 18
Signature of Additional Applicant/Insure	d/Claimant or Legal Representative	Signature of Applicant/Insured/C	Claimant Child (if age 18 or older)
Description of Legal Repres	entative's Authority for Applicant/Insur	red/Claimant (please indicate which Inc	dividual is represented)
,	, - , - , - , - , - , - , - , - , - , -	u ·	,,
Ol	RIGINAL TO HOME OFFICE, COPY	TO BE LEFT WITH APPLICANT	

75-502-05055 (R11-12) [FR.11.28.12]



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.

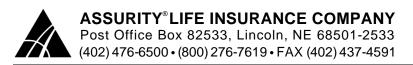
This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving 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.

75-652-05055 [R.04.07.09]



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.

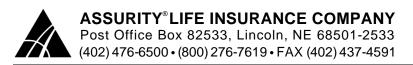
This Temporary Conditional Insurance Agreement is void if altered or modified. No agent is authorized to change or waive any terms, conditions or limitations stated herein.

Proposed Insured No. 1	Date Application Signed/ /
Proposed Insured No. 2	Date Application Signed / /
TERMS AND CONDITIONS	
In consideration of \$\frac{1}{2}\] in premium received by Assurity Life Insura will become effective under this Temporary Conditional Insurance Agreement (Again The effective date (Effective Date) of coverage under this Agreement will be the la Proposed Insured(s) is completed, if required by Assurity.	
Subject to the limitations below, insurance will become effective under this Agreem	nent 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 present	
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 com	•
 On the Effective Date, the Proposed Insured(s) is insurable at Assurity's sta Assurity's underwriting practices for the amount of insurance and any additional and additional actions. 	andard or better than average rates (no ratings included), according to onal benefits applied for; and
5. The Policy is issued by Assurity exactly as applied for within 90 days from the	
Except as stated herein, coverage under this Agreement is subject to the sam the Policy if issued as applied for.	e terms, including any limitations and exclusions, which would be part of
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.	age applied for with Assurity.
These limits continue until the insurance applied for is issued and delivered during	ng the Proposed Insured's lifetime and continued good health.
REFUND OF PAYMENT	
There will be no insurance coverage under this Agreement, and Assurity's liabili	ty 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

75-803-02255 (R07-12) [FR.07.09.12]

Signature of Owner (if other than Proposed Insured)





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 \$\frac{1}{2}\] in premium received by Assurity Life Insura will become effective under this Temporary Conditional Insurance Agreement (Again The effective date (Effective Date) of coverage under this Agreement will be the la Proposed Insured(s) is completed, if required by Assurity.	
Subject to the limitations below, insurance will become effective under this Agreem	nent 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 present	
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 com	•
 On the Effective Date, the Proposed Insured(s) is insurable at Assurity's sta Assurity's underwriting practices for the amount of insurance and any additional and additional actions. 	andard or better than average rates (no ratings included), according to onal benefits applied for; and
5. The Policy is issued by Assurity exactly as applied for within 90 days from the	
Except as stated herein, coverage under this Agreement is subject to the sam the Policy if issued as applied for.	e terms, including any limitations and exclusions, which would be part of
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.	age applied for with Assurity.
These limits continue until the insurance applied for is issued and delivered during	ng the Proposed Insured's lifetime and continued good health.
REFUND OF PAYMENT	
There will be no insurance coverage under this Agreement, and Assurity's liabili	ty 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

75-803-02255 (R07-12) [FR.07.09.12]

Signature of Owner (if other than Proposed Insured)





Accident or Sickness Insurance REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

	According to your application (<i>informatio</i> and sickness insurance Policy number	on you have furnished), you intend to lapse or otherwise terminate the existing accident you have with
sh		by Assurity Life Insurance Company. For your own information and protection, you er certain factors which may affect the insurance protection available to you under the
1.		ntly have (pre-existing conditions), may not be immediately or fully covered under the all or delay of a claim for benefits under the new policy, whereas a similar claim might t policy.
2.		f your present insurer or its agent regarding the proposed replacement of your present it it is also in your best interest to make sure you understand all the relevant factors verage.
3.	all questions on the application conce include all material medical informati and to refund your premium as though	rish to terminate your present policy and replace it with new coverage, be certain that erning your medical/health history are truthfully and completely answered. Failure to ion on an application may provide a basis for the company to deny any future claims h your policy had never been in force. After the application has been completed, it being signed to be certain that all information has been properly recorded.
4.		er age than that used for issuance of your present policy; therefore, the cost of the new may be higher than you are paying for your present policy.
5.	5. The renewal provisions of the new poli	icy should be reviewed so as to make sure of your rights to periodically renew the policy.
Τł	The above "Notice to Applicant" was del	livered to me on:
	Date (MM/DD/YYYY)	Applicant's Signature and Printed Name
		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.

54-809-05055 (FL) [R.02.06.08]





Accident or Sickness Insurance REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

	According to your application (<i>informatio</i> and sickness insurance Policy number	on you have furnished), you intend to lapse or otherwise terminate the existing accident you have with
sh		by Assurity Life Insurance Company. For your own information and protection, you er certain factors which may affect the insurance protection available to you under the
1.		ntly have (pre-existing conditions), may not be immediately or fully covered under the all or delay of a claim for benefits under the new policy, whereas a similar claim might t policy.
2.		f your present insurer or its agent regarding the proposed replacement of your present it it is also in your best interest to make sure you understand all the relevant factors verage.
3.	all questions on the application conce include all material medical informati and to refund your premium as though	rish to terminate your present policy and replace it with new coverage, be certain that erning your medical/health history are truthfully and completely answered. Failure to ion on an application may provide a basis for the company to deny any future claims h your policy had never been in force. After the application has been completed, it being signed to be certain that all information has been properly recorded.
4.		er age than that used for issuance of your present policy; therefore, the cost of the new may be higher than you are paying for your present policy.
5.	5. The renewal provisions of the new poli	icy should be reviewed so as to make sure of your rights to periodically renew the policy.
Τł	The above "Notice to Applicant" was del	livered to me on:
	Date (MM/DD/YYYY)	Applicant's Signature and Printed Name
		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.

54-809-05055 (FL) [R.02.06.08]



Name of Proposed Insured			
	First	Middle	Last
AUTOMATIC BANK WITHDRA	WAL AUTHORIZATION		
The company's authority to debi will be in force until the premium		m for this insurance does not begin un	til the date the policy is issued. No coverage
			used. Assurity will begin processing your bank account could be two or more days after the
I understand that initiating autom revoked by me in the manner protected in honoring any debit t	natic payments may result in additio rovided by law. Until it receives not	nal drafts to bring my account current. ice of such revocation, I agree that As hat if the date of the withdrawal is after	to my account listed below for all premiums. This authorization shall remain in effect until surity Life Insurance Company shall be fully the policy issue date and the premium is not
☐ Do not draft initial premium:	☐ Payment enclosed or ☐ F	Payment collected on delivery	
Type of Account:	☐ Savings		
Name of Fi	inancial Institution	Routing No. (9-digit number)	Account No.
Account Holder's Pri	inted Name (if other than Proposed Insure	ed/Owner) Relation	nship (if other than Proposed Insured/Owner)
Account Holder's Add	dress (Street Address, P.O. Box, City, Sta	ate, Zip+4)	Name of Authorized Officer (if any)
Olevanture of Assert	and Halder and Authorized Officers		()
Signature of Accou	unt Holder or Authorized Officer	Date (MM/DD/YYYY)	Telephone No.

TO ENSURE ACCURACY, SUBMIT VOIDED CHECK

(unless application is submitted electronically)

75-050-05055 (R11-10)