

**ASSURITY® LIFE INSURANCE COMPANY**

Toll-free Number: (800) 276-7619, Extension 4264

AssureLINK Address: <http://assurelink.assurity.com>**Disability Income
Business Overhead Expense**

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 proposed insured and the policy owner must be the same person.
- ✓ The application should coincide with the **state in which the policy owner resides** for the following states:
 - Disability Income: CA, FL, and MA
 - Business Overhead Expense: MT

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 nearest** (*age as of nearest birthday*) when preparing illustrations and/or calculating insurance premiums.
- ✓ Obtain all required signatures.
- ✓ Have the proposed insured initial any changes. Corrections with white correction fluid/tape are not acceptable.
- ✓ Comply with all state regulations.
- ✓ Complete all other pertinent and applicable forms padded together in this application.
- ✓ If faxing an application directly to the home office, fax to (877) 864-6630.
- ✓ If mailing directly to the home office, address to:

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

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



Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

**Application for
DISABILITY INCOME
INSURANCE**

1. PROPOSED INSURED				PLEASE PRINT IN BLUE OR BLACK INK			
Legal Name <i>First Middle Last</i>			Date of Birth <i>(MM/DD/YYYY)</i> / /				
Social Security No.		<input type="checkbox"/> Male <input type="checkbox"/> Female	Email		Age		
Home Address <i>Street Address City State ZIP+4</i>							
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? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If YES, please list type: _____ amount per day: _____ last date of use (MM/DD/YYYY) / /							
Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident status? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number. _____							
Is the Proposed Insured currently working at least 30 hours per week in primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of employment <i>Years Months</i> /							
Primary Employer		Employer's Address <i>Street Address City State ZIP+4</i>					
Full-time Employment <i>Occupation Duties</i>		Part-time Employment <i>Occupation Duties</i>					
Gross monthly income \$			If self-employed, net monthly income \$				
2. BENEFICIARIES							
If Beneficiary is a trust, or if additional space is needed, complete the Trust Information/Additional Beneficiary form.							
Primary Beneficiary Name (<i>First, Middle, Last</i>)		Relationship	Soc. Sec. No.	Date of Birth	Share %		
				/ /			
				/ /			
				/ /			
				/ /			
Contingent Beneficiary Name (<i>First, Middle, Last</i>)		Relationship	Soc. Sec. No.	Date of Birth	Share %		
				/ /			
				/ /			
				/ /			
				/ /			
3. PREMIUM PAYMENT							
Please indicate preference for payment type and billing frequency below:							
Type <input type="checkbox"/> Direct Billing <input type="checkbox"/> Automatic Bank Withdrawal <input type="checkbox"/> List Billing (<i>employer</i>)			Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (<i>not available with Direct Billing</i>)				
Payor Name <i>First Middle Last</i>			Billing Address <i>Street Address City State ZIP+4</i>				
Secondary Payor Info. <i>First Middle Last</i>			Billing Address <i>Street Address City State ZIP+4</i>				

GENERAL SECTION

Please answer the following questions. If additional space is needed, attach a separate sheet of paper.

1. Does any Proposed Insured belong to or currently have plans to join the National Guard or military?..... ☐ Yes ☐ No

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

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

b. Has any Proposed Insured participated in any hazardous sport or activities? ☐ Yes ☐ No

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

3. Does any Proposed Insured currently have plans to travel or reside outside of the United States during the next **12 months**? ☐ Yes ☐ No

If YES, please explain _____

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds?..... ☐ Yes ☐ No

If YES, please list Proposed Insured's name, amount of weight change and reason for change:

5. During the past **5 years**, has any Proposed Insured received benefit payments for disability or critical illness, or applied to organization or insurance any government company for such benefits?..... ☐ Yes ☐ No

If YES, please explain _____

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

If YES, please explain _____

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

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

If YES, please explain _____

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

If YES, please explain _____

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

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

Insured's Name	Company Name	Policy No.	Individual (I) Group (G)	Benefits (<i>monthly benefit and benefit period for DI or face amount for Life</i>)	Issue Date (MM/DD/YYYY)	DI Coverage Only	
						Coordinates w/ Soc. Sec.?	Employer Paid?
			<input type="checkbox"/> I <input type="checkbox"/> G		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> I <input type="checkbox"/> G		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> I <input type="checkbox"/> G		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH SECTION

Please answer the following questions to the best of your knowledge. If YES to any of the following, please provide details on page 4.

NOTICE: California law prohibits a human immunodeficiency virus (HIV) test from being required or used by health insurance companies as a condition of obtaining health insurance.

1.	During the past 5 years , has any Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:	
	a. Heart disorder, including a heart attack (<i>myocardial infarction</i>), angina, irregular heartbeat or irregular heart rhythm (<i>arrhythmia</i>), chest pain, hypertension (<i>high blood pressure</i>), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (<i>TIA or mini-stroke</i>), or rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders (<i>other than HIV</i>), elevated cholesterol, liver disease, hemophilia, kidney disease (<i>other than kidney stones</i>), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of the lymph nodes or any glandular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (<i>including Down's syndrome</i>), multiple sclerosis (<i>MS</i>), muscular dystrophy (<i>MD</i>), Parkinson's disease, amyotrophic lateral sclerosis (<i>ALS</i>), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (<i>COPD</i>), shortness of breath, asthma or disease of the lungs or respiratory system, rheumatoid arthritis, paralysis or connective tissue disorder (<i>lupus or scleroderma</i>)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	g. Arthritis, rheumatism or any disease of the musculoskeletal system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	i. Blindness, blurred vision, diplopia, optic neuritis, loss of hearing and/or tinnitus (<i>ringing of the ears</i>)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	j. Any other illness or injury requiring blood transfusions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	During the past 5 years , has any Proposed Insured:	
	a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Been treated by or diagnosed by a medical professional as needing treatment for drug or alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Been ordered by a medical professional to have any test (<i>other than HIV tests</i>), treatment, surgery or hospitalization, or been referred to a specialist for any appointment, test, treatment, surgery or hospitalization which has not been completed or for which results have not been received?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. Had any laboratory tests such as X-rays, electrocardiograms, blood tests (<i>other than AIDS-related blood tests</i>) or urine tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has any Proposed Insured been diagnosed as having, been treated or recommended for treatment by a medical professional for acquired immune deficiency syndrome (<i>AIDS</i>), AIDS-related complex (<i>ARC</i>), Addison's disease, allergies, anaphylaxis, celiac disease, chronic fatigue, colitis, Crohn's disease, fibromyalgia, irritable bowel syndrome, lupus, multiple sclerosis (<i>MS</i>) Parkinson's disease, rheumatoid arthritis, Reynaud's disease, Kawasaki disease or immunoglobulin E, A or M (<i>IgE, IgA, IgM</i>)?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death.	
		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. a.	During the past 5 years , has any Proposed Insured been treated for any disorder of any genital or reproductive organ or been treated for a miscarriage, stillbirth or Caesarean section?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Is any Proposed Insured currently pregnant?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If YES, date child is expected (<i>MM/DD/YYYY</i>) / /	

DETAILS: Enter complete details from questions #1-5 on page 4. If more space is needed, attach additional Supplemental Information form.

SUPPLEMENTAL INFORMATION

Question #/Letter	Name (First, Middle, Last)	Onset Date (MM/DD/YYYY)	Duration (Days, Mos, Yrs)	Health Condition and Details	Medical Care Provider's Name/Address/Phone
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Additional Information:

Home Office Use Only

DISABILITY INCOME PRODUCT SECTION

Please complete for either Individual Disability Income or Business Overhead Expense Disability Income.

Survivor Benefit Beneficiary Name _____
First Middle Last

Relationship to Insured _____ Date of Birth (MM/DD/YYYY) ____/____/____

INDIVIDUAL DISABILITY INCOME

Monthly Base Amount \$ _____ Occupation Class: ☐ 4 A ☐ 3 A ☐ 2 A ☐ 1 A

Elimination Period: ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days

Benefit Period: ☐ 1 Year ☐ 2 Years ☐ 5 Years ☐ 10 Years ☐ To age 65 ☐ To age 67

ADDITIONAL BENEFITS (If available)

Check benefit(s) desired and indicate amount requested.

- | | | |
|---|---|--|
| <input type="checkbox"/> Supplemental Disability Income Rider \$ _____ | <input type="checkbox"/> Guaranteed Insurability Rider | <input type="checkbox"/> Non-Cancelable Rider |
| <input type="checkbox"/> Critical Illness Benefit Rider \$ _____ | <input type="checkbox"/> Automatic Benefit Increase Rider | <input type="checkbox"/> Return of Premium Benefit Rider |
| <input type="checkbox"/> Other (Specify) _____ \$ _____ | <input type="checkbox"/> Retroactive Injury Benefit Rider | |
| <input type="checkbox"/> Own Occupation Rider (select desired Benefit Period) | <input type="checkbox"/> Residual Disability Benefit Rider (select desired Benefit Period) | |
| <input type="checkbox"/> 5-Year (not available with 1 or 2-Year Benefit Period) | <input type="checkbox"/> Rider Benefit Period matches Base Policy | |
| <input type="checkbox"/> 10-Year (available with 10-Year Benefit Period) | <input type="checkbox"/> 5-Year Rider Benefit Period (Not available with 1-year or 2-year Base Benefit Periods) | |
| <input type="checkbox"/> To Age 65 (available with To Age 65 Benefit Period) | | |
| <input type="checkbox"/> To Age 67 (available with To Age 67 Benefit Period) | | |

BUSINESS OVERHEAD EXPENSE DISABILITY INCOME

Monthly Base Amount \$ _____ Occupation Class: ☐ 4 A ☐ 3 A ☐ 2 A

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days

Benefit Period: ☐ 1 Year ☐ 2 Years

Average monthly expenses currently incurred, for which the Proposed Insured is liable:

Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
Employees' salaries	\$ _____	Accounting fees	\$ _____
Utilities (electricity, gas, water, telephone)	\$ _____	Property/payroll taxes	\$ _____
Business space (rent/mortgage payment)	\$ _____	Other eligible expenses (Please list)	
Furniture/equipment payments (lease or principal)	\$ _____		\$ _____
Laundry, office maintenance	\$ _____		\$ _____
Business insurance premiums	\$ _____		\$ _____
		Total Monthly Expenses	\$ _____

PHYSICIAN INFORMATION

Please list the last physician seen:

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

Address _____
Street Address Suite

City State ZIP+4

Phone No. () Fax No. ()

Is this your primary physician? ☐ Yes ☐ No

Reason for consultation _____

Results _____

AGREEMENT

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

I (We) agree that:

- a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.
- b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law. The falsity of any statement in the application for insurance shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Substitute Form W-9 information (Request for Taxpayer Identification Number and Certification): I, the Owner (or each Joint Owner), certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____ on _____ / _____ / _____
City State Date (MM/DD/YYYY)

Signature of Proposed Insured

Signature of Licensed Agent

Print Agent Name and Agent No.

FIELD UNDERWRITER'S STATEMENT

1. a. What amount was collected with this application? \$ _____
 b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ☐ No
 c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ☐ Yes ☐ No
2. a. Did you personally see all Proposed Insured(s) on the date of application? ☐ Yes ☐ No
 b. How well do you know the Proposed Insured(s)? ☐ Well ☐ Slightly ☐ Not at all
 c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? If YES, please provide details below. ☐ Yes ☐ No

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ☐ Yes ☐ No
Agent is responsible for scheduling exam items.
NOTE: ANY PREFERRED PLANS REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.
☐ Paramedical examination ☐ Blood Sample ☐ Urine Sample ☐ Electrocardiogram (EKG) ☐ Treadmill EKG ☐ Medical exam by physician
4. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No
5. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
6. Was sales material used in soliciting this application? ☐ Yes ☐ No
7. Was the sales material left with the applicant? ☐ Yes ☐ No
8. Was the sales material approved by Assurity Life Insurance Company? ☐ Yes ☐ No
9. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ % Agent No. _____ %

AUTOMATIC PAYMENT OPTIONS

- ☐ Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.
☐ Add to existing bank withdrawal—indicate other applicant and/or policy numbers _____
☐ Set up NEW credit card payment—submit signed authorization with the application.

LIST BILL

- ☐ Set up NEW list bill— submit signed authorization with the application.
☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

FOR TERM LIFE APPLICATION

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

\$350,000 and under: ☐ Select + NT ☐ Select NT ☐ Standard NT ☐ Select + T ☐ Select T ☐ Standard T
 \$350,001 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Standard NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

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

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

\$99,999 and under: ☐ Select NT ☐ Standard T
 \$100,000 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

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

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

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

Additional Insured's underwriting classification _____

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

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

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

_____ Signature of Soliciting Agent	_____ Date (MM/DD/YYYY)	_____ Business Phone No. and Fax No.
_____ Soliciting Agent's Printed Name	_____ Agent No.	_____ Agent's E-mail





Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-869-0355 | FAX 888-255-2060

**SECONDARY
ADDRESSEE NOTICE**

Your state law allows a secondary addressee to be designated. This addressee will be sent a copy of any reminder or lapse notice for this policy.

You may also make or change this designation at any time the policy is in force by contacting us in writing and providing the name and address of the secondary addressee. Please note you are not required to make this designation.

If you would like to designate a secondary addressee, please complete the information below and submit to Assurity Life Insurance Company at the address listed above.

Policy Number <i>(if applicable)</i>	Date <i>(MM/DD/YYYY)</i> / /
Insured's Name <i>(First, Middle, Last)</i>	Insured's Date of Birth / /
Owner's Name <i>(First, Middle, Last)</i>	Owner's Date of Birth / /
Name of Secondary Addressee <i>(First, Middle, Last)</i>	Secondary Addressee's Date of Birth / /
Address of Secondary Addressee <i>(Street Address, City, State, Zip+4)</i>	

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

Owner's Signature

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

Joint Owner's Signature





Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

**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*), financial institution or current or former employer, that has any medical, financial or employment records related to 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 sexually transmitted diseases and acquired immune deficiency syndrome (*AIDS*), excluding the results of tests for human immunodeficiency virus (*HIV*) unless the *Individual* has developed symptoms of *AIDS*.
- 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 or employer that has any medical records related to 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 records and information disclosed pursuant to this authorization will not be further disclosed unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

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, 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 877-864-6630**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*), financial institution or current or former employer, that has any medical, financial or employment records related to 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 sexually transmitted diseases and acquired immune deficiency syndrome (*AIDS*), excluding the results of tests for human immunodeficiency virus (*HIV*) unless the *Individual* has developed symptoms of *AIDS*.
- 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 or employer that has any medical records related to 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 records and information disclosed pursuant to this authorization will not be further disclosed unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

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, 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**



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*), financial institution, or current or former employer, that has any medical, financial or employment records related to 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 or employer that has medical records related to 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 records and information disclosed pursuant to this authorization will not be further disclosed unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

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 877-864-6630

**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*), financial institution, or current or former employer, that has any medical, financial or employment records related to 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 or employer that has medical records related to 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 records and information disclosed pursuant to this authorization will not be further disclosed unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

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

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.

Product Loss Ratio (nationwide for 2019)

Product loss ratio is the ratio of incurred claims to earned premiums.

Acci-Flex.....	32.8 percent
Simplified Critical Illness.....	10.6 percent
Critical Illness	15.8 percent
Disability Income	37.1 percent
Graded Benefit Disability Income	19.2 percent



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 _____ City, State	On _____ 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)	



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.

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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 _____ City, State	On _____ 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)	

**BLOOD TESTING WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE**

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

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw blood and order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the human immunodeficiency virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULTS

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test/screening results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the MIB, Inc. (*formerly known as Medical Information Bureau*), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

COST OF TESTING

The cost of any testing will be borne by the Insurer.

NOTIFICATION OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact your designated physician, or you if you have not designated a physician. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

I have read and I understand this Notice and Consent for Blood Testing, which will include HIV antibody/antigen testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood and the disclosure of the test results as described above.

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

Proposed Insured (Printed)

Date of Birth (MM/DD/YYYY)

Name and Address of Designated Physician:

Signature of Proposed Insured or Parent/Guardian

Date (MM/DD/YYYY)

State of Residence

COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Assurity Life Insurance Company (*Assurity*). Therefore, Assurity makes no representations or warranties that this information is accurate as of the date you receive this list. Also, Assurity makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE – U.S. PUBLIC HEALTH SERVICE
(800) 367-AIDS

AIDS HOTLINE – SOUTHERN CALIFORNIA
(800) 367-AIDS

SPANISH AIDS HOTLINE
(800) 344-7432

HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA
Social Services-Southern California
Hemophilia AIDS Information
(818) 792-6192
(714) 740-2222

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM - BAKERSFIELD
(661) 868-0366

CALIFORNIA DEPT. OF HEALTH SERVICES
Statewide Services – Office of AIDS – Sacramento
(916) 323-7415

CENTRAL VALLEY AIDS TEAM – FRESNO
(209) 264-2436

AIDS SVCS FOUNDATION OF ORANGE COUNTY – COSTA MESA
(949) 809-5700

AIDS PROJECT–EAST BAY – OAKLAND
(415) 420-8181

AIDS PROJECT – LOS ANGELES – WEST HOLLYWOOD
(213) 876-8951

SACRAMENTO AIDS FOUNDATION-SACRAMENTO
(916) 448-2437

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(760) 391-8828

SAN FRANCISCO AIDS FOUNDATION
San Francisco
(415) 846-5855

SAN DIEGO AIDS PROJECT
(619) 296-2120 – City of San Diego
(619) 945-6000 – City of Vista

SANTA CLARA COUNTY ARIS PROJECT
Campbell
(408) 792-3729

SANTA BARBARA COUNTY AIDS HOTLINE
(805) 681-5120

SONOMA COUNTY AIDS INFORMATION HOTLINE
(707) 579-AIDS
Social Services – Southern California

SHASTA COUNTY HELPLINE
(530) 225-5298



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 submitted by check/money order.

Frequency (*if no option is selected, Monthly will apply*): ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

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*)