Assurity®

Assurity's TeleApp

Apply for your policy in three easy steps

Congratulations on your decision to protect your financial future with insurance from Assurity. Assurity has a legacy of helping people through difficult times for generations and providing "best in class" service to our policyholders.

Thank you for completing the initial insurance paperwork with your agent. You may choose to submit the premium and/or an automatic bank withdrawal form now, or you can wait until the policy is approved. **If you choose to submit the premium now, a Temporary Conditional Agreement will need to be completed and submitted with the premium.**

1

Step 1: Telephone Interview

You will be contacted by phone to schedule a time to provide your medical history to an experienced telephone interviewer. We will work with your schedule so that your interview (approximately 20-30 minutes) is private and convenient for you. The information will be kept strictly confidential and used only for this application.

We strongly recommend that you gather the following information so the interview will go quickly. Please be prepared to provide:

- *Company names, insurance types and coverage amounts of your other life or health insurance policies*
- *Specific financial information (completed tax returns for the last two years)*
- *Medical information, including physicians' contact information; hospitalizations, office visits and treatments; and prescription drug history over the last two years; also be prepared to give the drug name, dosage and frequency*

Depending on the type of insurance for which you are applying, you may also need to provide the following:

- *Medical history for your parents and sibilings*
- *Driving history*
- *Leisure activities*

2

Step 2: Schedule Exam

During the phone interview, your interviewer may need to schedule a mini-medical exam, which may include providing blood and/or urine samples, at your convenience. A licensed professional can provide a short exam at home or work, or you may visit one of our affiliated medical facilities.

3

Step 3: Policy Approval & Delivery

Once Assurity has reviewed your information, your agent will inform you of the status of your paperwork. If your request is approved, your agent will deliver your policy to you, containing the completed application for you to review and sign. **The premium and/or an automatic bank withdrawal form can be collected at this time.**

Please feel free to call us at 877-611-4701 if you haven't received a phone call from our interview unit within five business days of completing your paperwork.

Interview hours are:
Monday through Thursday: 7 a.m.–9 p.m. (Central)
Friday: 7 a.m.–6 p.m. (Central)
Saturday: 9 a.m.–1 p.m. (Central)

15-148-05051 (Rev. 01/19)

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

TeleApp REQUEST FORM

PLEASE PRINT IN BLUE OR BLACK INK

To **Assurity Life Insurance Company** FAX **(877) 864-6630** Application State _____

Agent _____ Agent ID No. _____ Agent Phone No. ( )

PROPOSED INSURED

Legal Name (First, Middle, Last) | Date of Birth (MM/DD/YYYY) / /

Social Security No. | ☐ Male ☐ Female | E-mail | Age

Home Address (Street Address, City, State, ZIP+4) | Birth State/Country

Residence Phone No. ( ) | Cell Phone No. ( ) | Business Phone No. ( )

Driver's License No./State | Height ft. in. | Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

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

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

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

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No Length of employment Years / Months /

Primary Employer | Employer's Address (Street Address, City, State, ZIP+4)

Full-time Employment (Occupation, Duties) | Part-time Employment (Occupation, Duties)

Gross monthly Income $ | If self-employed, net monthly income $

POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

Legal Name (First, Middle, Last) | Date of Birth (MM/DD/YYYY) / /

Social Security No. | Relationship to Insured | Birth State/Country

Home Address (Street Address, City, State, ZIP+4) | E-mail

Contingent Owner's Name (First, Middle, Last) | Contingent Owner's Relationship to Insured

BENEFICIARIES

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

PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below:

Type

☐ Direct Billing ☐ Automatic Bank Withdrawal
☐ List Billing *(employer)*

Frequency

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

GENERAL SECTION

1. Is any Proposed Insured currently negotiating for other insurance coverage? ..... ☐ Yes ☐ No

   If YES, please explain: _____

2. a. Is other insurance coverage in force for any Proposed Insured? ..... ☐ Yes ☐ No
   b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ..... ☐ Yes ☐ No

   If either a or b is answered YES, complete and return the appropriate State Replacement Forms *(if applicable)*.

LIFE PRODUCT SECTION

Additional benefits for term life insurance may vary by state.

TERM LIFE INSURANCE

Face Amount $ _____ Number of years for policy: ☐ 10-Year ☐ 15-Year ☐ 20-Year ☐ 30-Year

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

☐ Disability Waiver of Premium Benefit Rider

☐ Monthly Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Critical Illness Benefit Rider for Primary Insured $ _____

☐ Children's Term Insurance Rider _____ units

☐ Other Insured Term Insurance Benefit Rider $ _____

☐ Monthly Disability Income Rider for Other Insured $ _____ mo. benefit

☐ Critical Illness Benefit Rider- Other Insured $ _____

☐ Return of Premium Rider

OTHER INSURED AND CHILD RIDER INFORMATION—If applying for Other Insured or Child Riders, please complete this section.

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name *(First, Middle, Last)*				
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to Proposed Insured				
Employer and Occupation/Duties				
Gross monthly income	$			
If self-employed, net monthly income	$			

Has the Other Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

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

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

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

If the Other Insured is not a United States citizen, how long has the Other Insured been in the United States? _____

AGENT STATEMENT

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

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

2. a. Did you personally see each Proposed Insured on the date of application? ☐ Yes ☐ No

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

   c. Did the Proposed Insured approach you to purchase insurance? If YES, list their stated need for the insurance _____ ☐ Yes ☐ No

   d. Did the Proposed Insured(s) directly respond to you regarding each application question? ☐ Yes ☐ No

   e. Was a government-issued picture ID requested and reviewed for the Proposed Insured, Owner and Payor? ☐ Yes ☐ No

   f. Was each Proposed Insured present, and did you witness their signatures at the time the application was taken? ☐ Yes ☐ No

   g. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured(s)? 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)* ☐ 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 Name _____ Agent's No. _____ _____ %

   Agent Name _____ Agent's 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 employer authorization form 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:

☐ Preferred Plus 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:

☐ Preferred Plus 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 Plus NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification: _____

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*

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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

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

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- 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.
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- 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.

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Confidential Information Authorization for Release of Psychotherapy Notes

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

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

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

Legal Name	***Date of Birth***	*Legal Name*	***Date of Birth***

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau),* 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.

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CONSUMER NOTICE

MIB Pre-Notice

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

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

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

Insurance Information Practices

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

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

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

Fair Credit Reporting Act

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

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

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

Telephone Interview Information

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

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

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

Temporary Conditional Insurance Agreement

(for use with Life and Reversionary Annuity products)

Proposed Insured No. 1 _____ Date Application Signed ___/___/___

Proposed Insured No. 2 _____ Date Application Signed ___/___/___

In consideration of the premium received with the life insurance application listed above *(Application)*, Assurity Life Insurance Company *(Assurity)* will provide temporary life insurance coverage subject to the terms and conditions contained in this Agreement. Make all checks payable to Assurity. Do not make checks payable to the agent. Do not leave the check payee blank.

NOTE: On questions 1-2 answer according to what product(s) is being applied for.
If questions 3 a-d are answered YES or are left BLANK, there will be NO CONDITIONAL COVERAGE
The agent is not authorized to accept a premium under these circumstances.

1. a. **LIFE**—Is any Proposed Insured younger than 15 days old or older than 75 years old? ☐ Yes ☐ No
   b. **LIFE**—Does the Application, combined with the total amount of insurance in force on any Proposed Insured's life with Assurity exceed $500,000 for ages 15 days through 69 years? ***or*** $250,000 for ages 70 through 75? ☐ Yes ☐ No
2. **Reversionary Annuity**—Does the in-force and applied for life coverage, including the present value of any reversionary annuity policy exceed $100,000? ☐ Yes ☐ No
3. Has any Proposed Insured:
   a. **Ever** had a heart, lung, liver or kidney disease or disorder; diabetes; stroke; paralysis or cancer? ☐ Yes ☐ No
   b. **Ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)* or AIDS-related complex *(ARC)*? ☐ Yes ☐ No
   c. During the past **5 years** been treated, counseled or advised to seek treatment for drug/alcohol abuse? ☐ Yes ☐ No
   d. During the past **90 days** been admitted, or advised by a medical professional to be admitted to a hospital or other licensed health care facility; had surgery or had surgery recommended by a medical professional; or been advised by a medical professional to have any diagnostic test that was not completed *(excluding an AIDS-related test)*? ☐ Yes ☐ No

No coverage starts:

- Until the later of **1)** the date the Proposed Insured completed and signed the Application and paid the first full modal premium *(a check is not payment unless honored by the issuing institution when first presented)*; or **2)** the date the Proposed Insured completed all medical tests required by Assurity **and**
- Unless the Proposed Insured is insurable on the date coverage starts at Assurity's **standard or better than average rates** *(no ratings included)*, according to its underwriting practices for the amount of insurance and any additional benefits applied for.

If Proposed Insured dies while coverage under this Agreement is in effect, Assurity will pay the death benefit payable if the Policy applied for would have been issued at standard rates. However, Assurity shall not be liable for payment of any benefit over the amount of $500,000 *($250,000 for ages 70 through 75)*. Coverage under this Agreement is subject to the same terms, including any limitations or exclusions, which would be part of the Policy if issued as applied for.

If no Policy is issued and delivered and no benefit is paid under this Agreement, all premiums paid will be returned. If the Policy is issued as applied for, or if a Policy amendment is accepted by the Proposed Owner, premium paid will be applied to that Policy. No change in health will be used to deny a Policy if the change occurs after the later of: **1)** the date of the Application; or **2)** completion of all medical tests required by Assurity.

Coverage under this Agreement terminates automatically on the earliest of the date:

- 90 days from the date of the Application;
- Premium is returned by Assurity *(return is effective on being postmarked, properly addressed and postage prepaid)*;
- Coverage starts under any Policy resulting from the Application; or
- A Policy resulting from the Application is refused by the Proposed Owner.

The undersigned states that the answers on this Agreement and the Application are true and complete to the best of his/her knowledge and belief, and understands that the answers are relied upon for coverage under this Agreement. Assurity's liability will be limited to a return of the premium submitted if: **1)** the Proposed Insured dies by suicide; or **2)** the Application or this Agreement contains a material misrepresentation to Assurity.

Dated at _____ On _____
City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

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1. a. **LIFE**—Is any Proposed Insured younger than 15 days old or older than 75 years old? ☐ Yes ☐ No
   b. **LIFE**—Does the Application, combined with the total amount of insurance in force on any Proposed Insured's life with Assurity exceed $500,000 for ages 15 days through 69 years? ***or*** $250,000 for ages 70 through 75? ☐ Yes ☐ No
2. **Reversionary Annuity**—Does the in-force and applied for life coverage, including the present value of any reversionary annuity policy exceed $100,000? ☐ Yes ☐ No
3. Has any Proposed Insured:
   a. **Ever** had a heart, lung, liver or kidney disease or disorder; diabetes; stroke; paralysis or cancer? ☐ Yes ☐ No
   b. **Ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)* or AIDS-related complex *(ARC)*? ☐ Yes ☐ No
   c. During the past **5 years** been treated, counseled or advised to seek treatment for drug/alcohol abuse? ☐ Yes ☐ No
   d. During the past **90 days** been admitted, or advised by a medical professional to be admitted to a hospital or other licensed health care facility; had surgery or had surgery recommended by a medical professional; or been advised by a medical professional to have any diagnostic test that was not completed *(excluding an AIDS-related test)*? ☐ Yes ☐ No

No coverage starts:

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City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

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NOTICE AND CONSENT FOR BLOOD TESTING

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

SPANISH AIDS HOTLINE
(800) 344-7432

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

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

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

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

SACRAMENTO AIDS FOUNDATION-SACRAMENTO
(916) 448-2437

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

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

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

AIDS HOTLINE – SOUTHERN CALIFORNIA
(800) 367-AIDS

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

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

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

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

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

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

SANTA BARBARA COUNTY AIDS HOTLINE
(805) 681-5120

SHASTA COUNTY HELPLINE
(530) 225-5298

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Life Insurance or Annuity
REPLACEMENT NOTICE

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

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

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

INFORMATION ON POLICIES WHICH MAY BE REPLACED

COMPANY NAME	POLICY NO.	NAME OF INSURED

To be completed if replacing another company's policy
Signed form to be returned to home office
Applicant to receive a copy of this form at the time the application is taken

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

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COMPANY NAME	POLICY NO.	NAME OF INSURED

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Life Insurance or Annuities
PURCHASER'S NOTICE

California Elder Notice to All Purchasers of Life Insurance or Annuities Age 65 or Over

You should be aware that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this life or annuity product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale or sold.

I have read the above notice and have received a copy.

Signature and Printed Name of Prospective Purchaser	*Date (MM/DD/YYYY)*
Signature and Printed Name of Prospective Purchaser's Spouse or Joint Owner	*Date (MM/DD/YYYY)*
Signature and Printed Name of Prospective Purchaser's Representative	*Date (MM/DD/YYYY)*

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I have read the above notice and have received a copy.

Signature and Printed Name of Prospective Purchaser	*Date (MM/DD/YYYY)*
Signature and Printed Name of Prospective Purchaser's Spouse or Joint Owner	*Date (MM/DD/YYYY)*
Signature and Printed Name of Prospective Purchaser's Representative	*Date (MM/DD/YYYY)*

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California Resident's
MEDI-CAL DISCLOSURE

NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

For Distribution by Insurers, Agents and Brokers

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

RECOVERY

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than $2,000 in countable resources. The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

- **Community Spouse Resource Allowance:** If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $126,420 in countable resources.
- **Minimum Monthly Maintenance Needs Allowance:** If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income, or $3,161 in monthly income, whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $126,420 in countable resources. The order also may allow the at-home spouse to retain more than $3,161 in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

- **One principal residence:** One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home some day. The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it. Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- **Real property used in a business or trade:** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

- **IRAs, Keogh plans, or other work-related pension plans:** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity or otherwise change the form of the assets in order for them to be unavailable.
- **Personal property used in a trade or business**.
- **One motor vehicle**.
- **Irrevocable burial trusts or irrevocable prepaid burial contracts**.

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

Purchaser's Signature and Printed Name	*Date (MM/DD/YYYY)*
Spouse's Signature and Printed Name	*Date (MM/DD/YYYY)*
Legal Representative's Signature and Printed Name	*Date (MM/DD/YYYY)*

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UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than $2,000 in countable resources. The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

- **Community Spouse Resource Allowance:** If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $126,420 in countable resources.
- **Minimum Monthly Maintenance Needs Allowance:** If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income, or $3,161 in monthly income, whichever is greater.

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Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $126,420 in countable resources. The order also may allow the at-home spouse to retain more than $3,161 in monthly income.

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- **One principal residence:** One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home some day. The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it. Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- **Real property used in a business or trade:** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

- **IRAs, Keogh plans, or other work-related pension plans:** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity or otherwise change the form of the assets in order for them to be unavailable.
- **Personal property used in a trade or business**.
- **One motor vehicle**.
- **Irrevocable burial trusts or irrevocable prepaid burial contracts**.

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

Purchaser's Signature and Printed Name	*Date (MM/DD/YYYY)*
Spouse's Signature and Printed Name	*Date (MM/DD/YYYY)*
Legal Representative's Signature and Printed Name	*Date (MM/DD/YYYY)*

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)

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

COVID-19 Questionnaire

PLEASE USE A SEPARATE FORM FOR EACH PROPOSED INSURED

Proposed Insured _____
First *Middle* *Last*

Proposed Insured's Social Security No. _____ Proposed Insured's Date of Birth _____

Completed By _____ Relationship to Proposed Insured _____
(If completed by someone other than Proposed Insured)

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. In the past **12 months**, has the Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for COVID-19? ☐ Yes ☐ No

   If YES, provide the date of diagnosis or treatment, any resulting medical complications of COVID-19 and the physician and/or medical facility consulted.

Date of Diagnosis or Treatment *(MM/DD/YYYY)*	Resulting Complications? If Yes, provide details below.	Physician/Medical Facility Consulted
/ /	☐ Yes ☐ No	
Details:		

2. In the past **3 months**, has the Proposed Insured been tested for COVID-19? ☐ Yes ☐ No

   If YES, provide date of test, result of test and physician and/or medical facility consulted.

Date of Test *(MM/DD/YYYY)*	Test Result	Physician/Medical Facility Consulted
/ /	☐ Positive ☐ Negative ☐ Unknown	

3. In the past **month**, has the Proposed Insured cohabited with an individual who tested positive for COVID-19? ☐ Yes ☐ No

   If YES, provide date of exposure, current treatment, and physician and/or medical facility consulted (if any).

Date of Exposure *(MM/DD/YYYY)*	Current Treatment	Physician/Medical Facility Consulted
/ /		

4. In the past **3 months**, has the Proposed Insured traveled outside of the United States? ☐ Yes ☐ No

   If YES, provide detail of all countries and cities visited and corresponding dates.

Date of Travel *(MM/DD/YYYY)*	Country Visited	Cities visited
/ / through / /		

AGREEMENT

I have read the above questions and declare the answers are complete and true to the best of my knowledge and belief. I understand this questionnaire will be used as a supplement to my application for insurance and agree it shall form a part of the policy if attached thereto.

	/ /
Signature of Proposed Insured or Source	*Date of Signature (MM/DD/YYYY)*