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:

- ✓ Juvenile contracts have only the Guaranteed Insurability Rider available.
- ✓ Use the appropriate application **for 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 in which the application is signed.**
- ✓ Use **age last birthday** when preparing illustrations and/or calculating insurance premiums.
- ✓ Obtain all required signatures.
- ✓ Have the proposed insured initial any changes. Corrections with white correction fluid/tape are not acceptable.
- ✓ Comply with all state regulations. Note: NAIC Model Illustration or disclosure statement must accompany this application.
- ✓ 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.

Stranger-Owned Life Insurance/Investor-Owned Life Insurance *(STOLI/IOLI)*

Assurity Life Insurance Company position on STOLI/IOLI

Assurity Life Insurance Company does not support the use of its life insurance products in situations involving Stranger- or Investor-Owned Life Insurance. The company will take all measures necessary to identify these situations and take appropriate action to disallow these transactions. The company views STOLI/IOLI transactions as an inappropriate use of insurance in violation of its intended purpose. In addition, such use of insurance products may be illegal or in connection with illegal activity based on state laws and regulations.

Definition

Any act, practice or arrangement to initiate or facilitate the issuance of a life insurance policy for the intended benefit of a person who, at the time of the policy origination, does not have an insurable interest in the life of the insured as defined by the company's insurable interest guideline.

Actions

Safeguards and procedures are in place to identify STOLI/IOLI transactions during the underwriting and issue process. Any activities identified as being in violation of our company position will lead to action including, but not limited to, cancellation of the application or policy and termination of the producer/agent contract(s) and appointment with Assurity Life Insurance Company.

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

Application for INDIVIDUAL UNIVERSAL LIFE INSURANCE

PLEASE PRINT WITH BLACK INK

PROPOSED INSURED

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

Social Security No. | ☐ Male ☐ Female | Email | Age

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

Personal Phone No. ( ) | Birth State/Country | Height ft. in. | Weight lbs.

During the past 10 years:

1. Has the Proposed Insured used any form of tobacco, nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No
   a. If YES, please list type _____ Amount per day _____ Last date of use (MM/DD/YYY) / /
2. Has the Proposed Insured used any form of marijuana? ..... ☐ Yes ☐ No
   a. IF YES, were you prescribed cannabis by a licensed medical professional? ..... ☐ Yes ☐ No
   b. IF YES, please list last date of use (MM/DD/YYY) / /
   c. IF YES, please explain your use _____

Is the Proposed Insured a United States citizen? ..... ☐ Yes ☐ No

If NO, is the Proposed Insured a permanent resident? ☐ Yes ☐ No If YES, please list green card number. _____

Has the proposed insured resided in the US for at least 12 consecutive months? ..... ☐ Yes ☐ No

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ 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? ☐ 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)*

If Ownership is a trust, complete the Trust Policyowner section *(below)* rather than this section.

Legal Name (First, Middle, Last) | Phone No. ( ) | Date of Birth (MM/DD/YYYY) / /

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

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

Contingent Owner's Name (First, Middle, Last) | Contingent Owner's Phone No. ( )

Contingent Owner's Social Security Number | Contingent Owner's Relationship to Insured

TRUST POLICYOWNER

Name of Trust | Date of Trust (MM/DD/YYYY) / /

Name of Trustee(s) | Trustee(s) Phone Number ( ) | Tax ID No.

Address of Trustee(s) (Street Address, City, State, ZIP+4)

SECONDARY ADDRESSEE

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

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

CHILD RIDER INFORMATION If additional space is needed, attach a separate sheet of paper.				
Information	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3	Child Rider No. 4
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				

1. During the past 10 years, has any Proposed Insured Child:
   a. Been diagnosed with or treated for internal cancer or tumor, lymphoma, leukemia, disease of the lymph nodes or glandular disease? ☐ Yes ☐ No
   b. Been diagnosed with or treated for heart disease? ☐ Yes ☐ No
2. During the past 5 years, has a medical professional ordered any test (other than HIV tests), treatment, surgery or hospitalization, for any Proposed Insured Child which has been scheduled but not completed, and/or ordered tests which have already been conducted for which the Proposed Insured Child is currently awaiting results? ☐ Yes ☐ No

   If YES to any of the above, please list child(ren)'s name(s) _____

BENEFICIARY/TRUST INFORMATION If additional space is needed, attach a separate sheet of paper.

If Beneficiary is a trust, complete the Trust Information section below.

BENEFICIARY INFORMATION

Primary Beneficiary Name *(First, Middle, Last) AND Address (Street Adress, City, State, ZIP)*	Relationship	Soc. Sec. No.	Phone No.	Date of Birth	Share %
Name: Address:			( )	/ /	
Name: Address:			( )	/ /	
Name: Address:			( )	/ /	
Contingent Beneficiary Name *(First, Middle, Last) AND Address (Street Adress, City, State, ZIP)*	**Relationship**	**Soc. Sec. No.**	**Phone No.**	**Date of Birth**	**%**
Name: Address:			( )	/ /	
Name: Address:			( )	/ /	
Name: Address:			( )	/ /	

TRUST BENEFICIARY

☐ Primary Beneficiary ☐ Contingent Beneficiary

☐ Testamentary Trust *(Will)* Share % _____

☐ Living Trust *(Please complete information below.)* Share % _____

Name of Living Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Trustee(s) Phone Number ( )

Address of Trustee(s) *Street Address* *City* *State* *ZIP+4*

PREMIUM PAYMENT Please indicate preference for payment type and billing frequency below

What amount was collected with this application? $ _____

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

	First	*Middle*	*Last*		*Street Address*	*City*	*State*	*ZIP+4*
Payor Name				Billing Address				

PRODUCT UNIVERSAL LIFE INSURANCE

Benefits Available on Universal Life – Check benefit(s) desired and indicate amount requested where applicable.

Face Amount $ _____ ☐ Option 1 – Level ☐ Option 2 – Accumulating *(If no option is selected, Option 1 will apply.)*

Life Insurance Test Option: ☐ Guideline Premium Test ☐ Cash Value Accumulation Test *(If no option is selected, Guideline Premium Test will apply.)*

Planned Periodic Premium $ _____ Frequency: ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly*
**(not available with Direct Billing)*

Special Policy Date (*if desired)* ____/____/____

Answer only if applying for the Critical Illness rider. Do all Proposed Insureds currently have comprehensive health insurance benefits from an insurance policy, HMO plan or other health benefit plan? ..... ☐ Yes ☐ No

If NO, indicate below all Proposed Insureds who do not have such coverage as they are not eligible for this rider.

_____

Riders Available

☐ Children's Term Rider $ _____

(The Child Rider Information Section on Page 2 must be completed.)

☐ Critical Illness Rider $ _____

☐ Guaranteed Insurability Rider $ _____

☐ Level Term Rider $ _____

- ☐ 10-Year
- ☐ 20-Year
- ☐ 30-Year

Additional Universal Life Information

1. What is the purpose of this insurance? ☐ Personal ☐ Key Person ☐ Buy/Sell ☐ Business Loan ☐ Charitable Giving ☐ Other _____

2. a. Are there any agreements in place to assign/sell the policy? ..... ☐ Yes ☐ No

   b. Has the insured undergone any life expectancy or health exams in conjunction with a settlement option contract? ..... ☐ Yes ☐ No

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 have they entered into a written agreement to become a member of the military or National Guard? ☐ 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 scheduled to fly as a pilot, crew member or student, or enrolled in flight school? ☐ Yes ☐ No

   b. Has any Proposed Insured participated in any of the following sports 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/Rock/Ice Climbing ☐ Hot Air Ballooning

3. Has the Proposed Insured purchased plane tickets, reserved lodging or housing or made other arrangements to reside or travel 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 details: diet/better eating, exercise, childbirth, or other:

   _____

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

   If YES, please explain _____

6. Is any Proposed Insured currently negotiating 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 pled guilty or been convicted of any moving violations? ☐ Yes ☐ No

   If YES, please explain _____

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

   If YES, please explain _____

8. Is any Proposed Insured currently on probation? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

   _____

9. Has any Proposed Insured ever filed for bankruptcy? ☐ Yes ☐ No

   If YES, when? _____ Has the bankruptcy been discharged? ☐ Yes ☐ No If YES, when? _____

10. a. Does any Proposed Insured have other insurance coverage in force? ☐ Yes ☐ No
    If YES, provide details below.

    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 form.

Company Name	Type of Coverage	Amount of Coverage	Replacing, modifying or borrowing against?
			☐ Yes ☐ No
			☐ Yes ☐ No

11. **If the Proposed Insured is a juvenile**, please list the total amount of life insurance in force and pending on **all** family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
$	$	$	$	$	$	$

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 6.

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 disease, including a heart attack *(myocardial infarction)*, angina, irregular heartbeat or abnormal heart rhythm *(arrhythmia)*, chest pain, hypertension *(high blood pressure)*, heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack *(TIA or mini-stroke)*, or rheumatic fever? ☐ Yes ☐ No

   b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disease *(other than HIV)*, elevated cholesterol, liver disease, hemophilia, kidney disease *(other than kidney stones)*, protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? ☐ Yes ☐ No

   c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disease of the lymph nodes or any glandular disease? ☐ Yes ☐ No

   d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation *(including Down syndrome)*, multiple sclerosis *(MS)*, muscular dystrophy *(MD)*, Parkinson's disease, amyotrophic lateral sclerosis *(ALS)*, any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy? ☐ Yes ☐ No

   e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease *(COPD)*, shortness of breath, or asthma or other respiratory disease? ☐ Yes ☐ No

   f. Dizziness, fainting spells or anxiety, depression, chronic fatigue, eating disorders or any other psychological or emotional disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV)* published by the American Psychiatric Association (or its prior or subsequent editions or replacement)? ☐ Yes ☐ No

   g. Any disease or disorder of the back, spine, bones, joints or muscles, including but not limited to arthritis, fibromyalgia, paralysis or connective tissue disorder (such as lupus or scleroderma), kyphosis, fracture, or nerve impingement? ☐ Yes ☐ No

   h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? ☐ Yes ☐ No

   i. Any disease of the eyes, ears, nose or throat (for example: blindness, blurred vision, diplopia, optic neuritis, loss of hearing or tinnitus (ringing of the ears), Barrett's esophagus or deviated nasal septum)? ☐ Yes ☐ No

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

   a. Required a transfusion of whole blood or blood products, including platelets, packed red blood cells or plasma? ☐ Yes ☐ No

   b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? ☐ Yes ☐ No

   c. Been treated or diagnosed by a medical professional as needing treatment for drug or alcohol use? ☐ Yes ☐ No

   d. Been diagnosed as having, or been treated by a medical professional for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? ☐ Yes ☐ No

3. During the past **5 years**:

   a. Has any Proposed Insured been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? ☐ Yes ☐ No

   b. Has a medical professional ordered any test (other than HIV tests), treatment, surgery or hospitalization, for any Proposed Insured which has been scheduled but not completed, and/or ordered tests which have already been conducted for which the Proposed Insured is currently awaiting results? ☐ Yes ☐ No

   c. Has any Proposed Insured had any laboratory tests such as X-rays, electrocardiograms, blood tests *(other than AIDS-related blood tests)* or urine tests? ☐ Yes ☐ No

4. Has any Proposed Insured had a natural parent or sibling who was diagnosed by a medical professional with or died of cancer, heart disease, diabetes, Huntington's disease or polycystic kidney disease prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, diagnosis and age at death. ☐ Yes ☐ No

HEALTH SECTION Continued.

5. a. During the past 10 years, has any Proposed Insured been treated for any disease of any genital or reproductive organ or been treated for a miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No

b. Is any Proposed Insured currently pregnant? ☐ Yes ☐ No

If YES, date child is expected *(MM/DD/YYYY)* ____/____/____

6. Is any Proposed Insured currently taking any prescription medication? ☐ Yes ☐ No

DETAILS: Enter complete details from question numbers 1-6 below. If more space is needed, attach additional Supplemental Information form.

SUPPLEMENTAL HEALTH 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:

PHYSICIAN INFORMATION

Please list the last physician consulted:

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 minimum premium (monthly lapse protection 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 minimum premium (monthly lapse protection 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 minimum premium (monthly lapse protection premium) is paid during the Proposed Insured's lifetime and the answers on the application remain true, complete and accurate as of the date the minimum premium (monthly lapse protection premium) is paid. 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.

d. If the Policyowner is someone other than the Insured, in the event of the Policyowner's death (and no Contingent Owner(s) living), the Insured will become the Policyowner.

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, 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 Parent/Guardian of Minor Child*

_____
Signature of Owner (If other than Proposed Insured)

_____ _____
Signature of Licensed Agent *Print Agent Name and Agent No.*

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.

   ☐ 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. *(Only available through the e-app process.)*

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 ☐ Standard 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 ☐ Standard 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*

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)

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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.

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

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

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Confidential Information Authorization for Release of Psychotherapy Notes

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

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

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- 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.

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ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 888-255-2060

CONSUMER NOTICE

MIB Pre-Notice

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

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

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

Insurance Information Practices

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

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

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

Fair Credit Reporting Act

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

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

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

Telephone Interview Information

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

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® 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)

Please make premium check(s) payable to Assurity Life Insurance Company. Do not make checks payable to the agent. Do not leave the check payee blank.

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

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

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

TERMS AND CONDITIONS

In consideration of $_____ in premium received by Assurity Life Insurance Company *(Assurity)* for an insurance Policy on the life of the Proposed Insured(s), and subject to the limitations stated herein, insurance will become effective under this Temporary Conditional Insurance Agreement *(Agreement)* if all of the terms and conditions stated below are fulfilled exactly. The effective date *(Effective Date)* of coverage under this Agreement will be the later of: i) the date of application; or ii) the date any medical examination of the Proposed Insured(s) is completed, if required by Assurity.

Subject to the limitations below, insurance will become effective under this Agreement on the Effective Date if the following conditions are fulfilled exactly:

1. The first full premium has been paid and the check is honored on first presentation for payment;
2. The application and any required medical examination(s) are completed in full;
3. On the Effective Date, all statements given in the application are true and complete;
4. On the Effective Date, the Proposed Insured(s) is insurable at Assurity's **standard or better than average rates** *(no ratings included)*, according to Assurity's underwriting practices for the amount of insurance and any additional benefits applied for; and
5. The Policy is issued by Assurity exactly as applied for within 90 days from the date of application, delivered and accepted by the Proposed Insured(s).

Except as stated herein, coverage under this Agreement is subject to the same terms, including any limitations and exclusions, which would be part of the Policy if issued as applied for.

MAXIMUM AMOUNT LIMITATION

Assurity's maximum liability under this Agreement shall not exceed the amount of $500,000 if the Proposed Insured(s) is within ages 15 days through 69 years, or $250,000 if the Proposed Insured(s) is within ages 70 through 75, reduced by the face amount of any life insurance and by the present value of any reversionary annuity then in force or pending with Assurity. These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.

REFUND OF PAYMENT

There will be no insurance coverage under this Agreement, and Assurity's liability will be limited to a return of the premium submitted if:

- The Policy applied for is not issued within 90 days of the date of application;
- Any of the terms or conditions set forth in this Agreement are not satisfied;
- The Proposed Insured(s) dies by suicide; or
- The application contains a material misrepresentation to Assurity.

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

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

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

_____
Signature of Owner (if other than Proposed Insured)

Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
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Proposed Insured No. 1 _____ Date Application Signed ___/___/___

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

TERMS AND CONDITIONS

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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
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There will be no insurance coverage under this Agreement, and Assurity's liability will be limited to a return of the premium submitted if:

- The Policy applied for is not issued within 90 days of the date of application;
- Any of the terms or conditions set forth in this Agreement are not satisfied;
- The Proposed Insured(s) dies by suicide; or
- The application contains a material misrepresentation to Assurity.

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

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

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

_____
Signature of Owner (if other than Proposed Insured)

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

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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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

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

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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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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Illustration Disclosure Statement

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

Name of Agent preparing disclosure _____
First *Middle* *Last*

Proposed Insured's acknowledgement and Agent's certification that:

☐ Application differs from illustration

☐ No illustration used in sales process

☐ Illustrations provided on computer screen. If a computer screen illustration was used, it was based on the following:

Gender: ☐ Male ☐ Female

Age _____

Product Name and Form No. _____

Premium Amount _____

Riders and Form No. _____

Guaranteed Interest Rate _____

Underwriting Class _____

Non-Guaranteed Interest Rate _____

Dividend Option _____

No. of Policy Years Illustrated _____

Initial Death Benefit _____

Assumed No. of Years of Premium _____

PROPOSED INSURED ACKNOWLEDGMENT

I acknowledge that I did not receive an illustration matching my application for insurance for the reason marked above. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

_____ _____
Date (MM/DD/YYYY) *Proposed Insured's Signature*

AGENT CERTIFICATION

I certify that:

a. An illustration matching the application for insurance was not provided at time of sale for the reason marked above.
b. I explained that a conforming illustration would be produced and delivered no later than at the time of policy delivery.
c. I have made no statements that are inconsistent with the illustration that will be produced.

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

Any Proposed Insured residing in MA, ME, PA, SD or WA must retain a copy of this completed form.

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Customer Identification INFORMATION

PLEASE PRINT WITH BLACK INK

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

Legal name of Policyowner _____ Social Security number _____

Policyowner's occupation _____

1. Source of funds

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

_____

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

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

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

3. Intended purpose of coverage applied for

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

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

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

5. Agent/Policyowner relationship

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

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

_____

_____

7. The information on this form was obtained from

Name _____

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

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

_____ _____

Producer Signature *Producer No.*

_____ / /

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

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

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)

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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)*