Apply for your policy in four easy steps...

Congratulations on your decision to protect your personal or business's financial future with insurance from Assurity Life Insurance Company. Assurity Life has been helping people through difficult times for generations and takes pride in providing "best in class" service to our policyholders.

Step 1

You've taken the first step by completing the initial insurance paperwork with your agent. You will make no premium payment at this time.

Step 2

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 time (approximately 15 minutes) is private and convenient for you. The information is strictly confidential and used only for this application.

My interview is scheduled between ____________ and _________ a.m./p.m. on ________________________________ at this phone number: __________________________

Step 3

You will want to gather the following information so the interview will go quickly. Please be prepared to provide:

- Current height and weight.
- Names, addresses and phone numbers of your physicians over the last five years.
- Information about any hospitalizations and/or physicians' office visits/treatment.
- Prescription drug history over the last two years. Please have your prescription containers on hand so you will be able to give the drug name, dosage and frequency.
- Company names, insurance types and coverage amounts of your other life or health insurance policies.

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 siblings (including death from diabetes, cardiovascular disease or cancer prior to age 60).
- Driving history.
- Leisure activities.

For disability income insurance applications, you will need:

- Specific financial information (complete tax returns for the last two years).

Continued on next page...

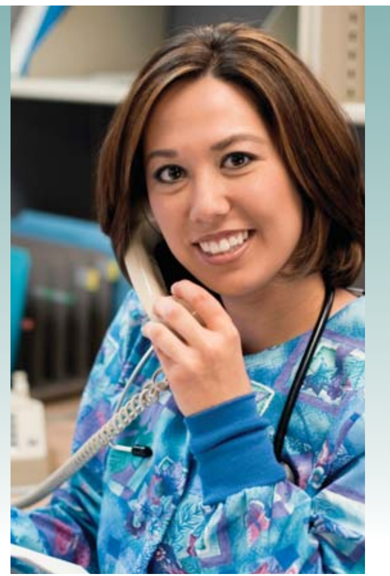
Step 4

During the phone interview, your interviewer may want to schedule a mini-medical exam at your convenience. A licensed professional can provide a short exam at home, work, or you may choose to visit one of our affiliated medical facilities. The following may be included:

- Blood pressure, pulse, height and weight measurements
- Blood and/or urine samples
- Electrocardiogram

My medical exam is scheduled between
__________ and ________ a.m./p.m. on
______________________________ at
____

Once Assurity Life has reviewed your information, we will inform you (through your agent) of the status of your paperwork. If your request is approved, your agent will deliver your policy to you, along with the completed application for you to review and sign.



Insurance protection is an important component in securing your financial future. Thank you for choosing Assurity Life for your insurance protection needs.

If you have questions or concerns regarding your new policy or this application process, please contact your agent or call Assurity Life at (800) 869-0355.

About Assurity

Assurity Life Insurance Company's origins are rooted in a century-long legacy of providing long-term security to policyholders that has earned generations of customers' confidence and trust.

Assurity Life serves customers across the nation, offering disability income, critical illness, long term care and life insurance, annuities and specialty insurance plans through our representatives, worksite distribution and direct mail. Pension and investment management services are available through Pine Lake Advisors Inc., a subsidiary of Assurity Life.

With assets exceeding $2 billion, Assurity Life has built a reputation for "best in class" service and sound, conservative business practices with a disciplined approach to financial management. Headquartered in Lincoln, Neb., Assurity Life has earned a high rating from A.M. Best Company, the insurance industry's leading independent analyst. For more information about this rating, please visit www.ambest.com or www.assurity.com.

We're proud of our history of integrity, financial accountability… and helping people through difficult times.

15-148-05051-A (Rev. 6-07)

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

TeleApp REQUEST FORM

PLEASE PRINT WITH BLACK INK

To **Assurity Life Insurance Company** FAX **(402) 437-4591** Application State ______

Agent ______ Agent ID No. ______ Agent Phone No. ( )

PROPOSED INSURED

Legal Name (First / Middle / Last) ☐ Male ☐ Female

Social Security No. | Age | Birth State/Country | Date of Birth (MM/DD/YYYY) / /

Home Address (Street Address / City / State / ZIP)

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

Driver's License No./State

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 and last date of use *(MM/DD/YYYY)* / /

Primary Employer

Employer's Address (Street Address / City / State / ZIP)

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No If YES, length of employment? (Years/Months) /

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

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

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

Social Security No. | Date of Birth (MM/DD/YYYY) / / | Birth State/Country

Home Address (Street Address / City / State / ZIP)

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

BENEFICIARIES

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	

Contingent Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	

PREMIUM PAYMENT MODE

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly *(Automatic Bank Withdrawal)* ☐ Monthly *(Automatic Credit Card)* ☐ List Bill

GENERAL SECTION

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

If YES, please explain: ______

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

LIFE PRODUCT SECTION

Additional benefits for term and whole life insurance may vary by state.

TERM LIFE INSURANCE

Base 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
- ☐ Accident Only Disability Income Rider for Primary Insured $ ______ mo. benefit
- ☐ Critical Illness Benefit Rider for Primary Insured $ ______
- ☐ Children's Term Insurance Rider *(complete next page)* ______ units
- ☐ Other Insured Term Insurance Benefit Rider *(complete next page)* $ ______
- ☐ Monthly Disability Income Rider for Other Insured *(complete next page)* $ ______ mo. benefit
- ☐ Accident Only Disability Income Rider for Other Insured *(complete next page)* $ ______ mo. benefit
- ☐ Critical Illness Benefit Rider-Other Insured *(complete next page)* $ ______
- ☐ Return of Premium Benefit Rider

WHOLE LIFE INSURANCE

Base Amount $ ____________

If cash value is available, should the Automatic Premium Loan *(APL)* provision be made effective? *(If no option chosen, APL will apply.)* ☐ Yes ☐ No

Nonforfeiture Option: *(If no option chosen, ETI will apply)* ☐ Extended Term Insurance *(ETI)* ☐ Reduce Paid-Up Insurance *(RPU)*

Dividend Option: *(If no option chosen, PUA will apply)* ☐ Paid-Up Additions *(PUA)* ☐ Accumulate at Interest ☐ Reduced Premium/PUA ☐ Reduce Premiums/Cash ☐ Paid in Cash

ADDITIONAL BENEFITS AVAILABLE ON WHOLE 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
- ☐ Accident Only Disability Income Rider for Primary Insured $ ______ mo. benefit
- ☐ Critical Illness Benefit Rider for Primary Insured $ ______
- ☐ Children's Term Insurance Rider *(complete next page)* ______ units
- ☐ Protected Insurability Benefit Rider $ ______
- ☐ Monthly Disability Income Rider for Other Insured *(complete next page)* $ ______ mo. benefit
- ☐ Accident Only Disability Income Rider for Other Insured *(complete next page)* $ ______ mo. benefit
- ☐ Critical Illness Benefit Rider-Other Insured *(complete next page)* $ ______
- ☐ Accidental Death Benefit Rider $ ______

☐ Level Term Insurance Benefit Rider for Primary Insured *(Select only one)*: ☐ 10-Year ☐ 20-Year $ ______

☐ Level Term Insurance Benefit Rider — Other Insured *(Select only one)*: ☐ 10-Year ☐ 20-Year $ ______

☐ Payor Benefit Rider *(Complete Health Section for Payor)* Payor Name ____________ DOB ___ / ___ / ___ ☐ M ☐ F

☐ Paid-Up Additions Rider *(VER)* ☐ Periodic Premiums $ ______ ☐ Single Premium $ ______

SINGLE PREMIUM WHOLE LIFE INSURANCE—If no dividend option is chosen, Paid-Up Additions will apply.

Base Amount $ ____________ **Dividend Option:** ☐ Paid-Up Additions ☐ Accumulate at Interest ☐ Paid in Cash

UNIVERSAL LIFE INSURANCE

Plan of Insurance *(Specify UL plan name)* ____________ If applying for a rider marked with an asterisk, complete the next page.

Base Amount $ ____________ Special Policy Date *(if desired)* ___ / ___ / ___

Planned Periodic Premium $ ____________ Amount of insurance is Face Amount unless shown differently here: ☐ Face + Accumulated Value

ADDITIONAL BENEFITS ***(if available)*** **Check benefit(s) desired and indicate amount requested where applicable.**

☐ Accidental Death Benefit Rider $ ______ ☐ Face Amount Increase Rider $ ______ ☐ Children's Term Insurance Rider*

☐ Disability Waiver Term Rider: ☐ 10-Year ☐ 20-Year $ ______ Additional Insured/Spouse Rider*: ☐ 10-Year ☐ 20-Year $ ______

LIFE PRODUCT SECTION *(continued)*

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
Relationship to Proposed Insured				
Employer				
Occupation				
Gross monthly income	$			
If self-employed, net mo. income	$			

Has the Other Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ☐ Yes ☐ No
(Not applicable to Child Riders.)

If YES, please list type and last date of use *(MM/DD/YYYY)* / /

FIELD UNDERWRITER'S STATEMENT *(DO NOT COLLECT PREMIUM WITH THIS REQUEST FORM)*

Please answer the following questions:

1. Has the Proposed Insured signed a Confidential Information Authorization and been given a Fair Credit and MIB Notification? .... ☐ Yes ☐ No

2. a. Did you personally see all Proposed Insured(s) on the date you completed this form? .... ☐ Yes ☐ No

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

   c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? If YES, please provide details below. .... ☐ Yes ☐ No

   ____

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

   If YES, and the Proposed Insured has permanent resident status, please list their permanent resident *(green card)* number ______________

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

4. Are commissions to be split? ☐ Yes ☐ No Agent No. ____________ ______% Agent No. ____________ ______%

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—signed authorization and voided check attached with the application.

☐ Add to existing bank withdrawal; indicate other applicant and/or policy numbers ______________________________

☐ Set up NEW credit card payment—signed authorization attached with the application.

LIST BILL

☐ Set up NEW list bill.

☐ Add to existing list bill; indicate list bill no. ______________ and/or name of company ______________________________

UNDERWRITING CLASSIFICATION

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

Term Life:	$350,000 and under:	☐ Select + NT	☐ Select NT	☐ Standard NT	☐ Select + T	☐ Select T	☐ Standard T
	$350,001 and over:	☐ Preferred + NT	☐ Preferred NT	☐ Standard NT	☐ Preferred T	☐ Standard T	
Whole Life:	$99,999 and under:	☐ Preferred +	☐ Preferred	☐ Select NT	☐ Tobacco		
	$100,000 and over:	☐ Preferred + NT	☐ Preferred NT	☐ Standard NT	☐ Preferred T	☐ Standard T	

All LifeScape® Whole Life cases require that either a signed illustration or a signed Illustration Disclosure Statement be submitted with the application.

Universal Life: ☐ Preferred + ☐ Preferred ☐ Select NT ☐ Preferred T ☐ Standard T

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*

For Home Office Use Only: Date Received ____/____/________ Policy No. ______________________________

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

Confidential Information AUTHORIZATION

_______________________________ Name of Applicant/Insured/Claimant (Please print)

___ / ___ / ___ Date of Birth (MM/DD/YYYY)

_______________________________ Name of Additional Applicant/Insured/Claimant (Please print)

___ / ___ / ___ Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant Child(ren)

Name	Date of Birth	Name	Date of Birth

I, on behalf of myself or the person named above *(Individual)*, authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau *(MIB)*, consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company *(Assurity)*, its reinsurers and/or consumer reporting agencies and their authorized representatives ***(provided, however, consumer reporting agencies may not collect information under this authorization from the MIB)***:

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation)*, occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus *(HIV)* infection and sexually transmitted diseases *(**Except** information about human immunodeficiency virus (HIV) infection for Individuals residing in Maine or Vermont.)*. **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- 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 session 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.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in 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 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, the Medical Information Bureau *(MIB)*, consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

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

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

_______________ Date (MM/DD/YYYY)

_______________ Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

_______________ Signature of Additional Applicant/Insured/Claimant or Legal Representative

_______________ Signature of Applicant/Insured/Claimant Child (if age 18 or older)

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

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (888) 255-2060

CONSUMER NOTICE

MIB Pre-Notice

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

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

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

Insurance Information Practices

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

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

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

Fair Credit Reporting Act

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

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

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

Telephone Interview Information

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

ASSURITY® LIFE INSURANCE COMPANY
1526 K Street, P.O. Box 82533, Lincoln, NE 68501
402.476.6500 • 800.276.7619 • FAX 402.437.4591

NOTICE AND CONSENT FOR BLOOD TESTING

BLOOD TESTING MAY INCLUDE AIDS VIRUS *(HIV)* ANTIBODY/ANTIGEN TESTING

INSURER: Assurity Life Insurance Company • P.O. Box 82533 • 1526 K Street • Lincoln, Nebraska 68501-2533

EXAMINER: ____

Name *Address*

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 insurance.

Due to the serious nature of HIV-related illnesses, you may wish to obtain counseling, at your expense, prior to undergoing the HIV-related test.

Information regarding alternative HIV-related testing and counseling is provided by the Pennsylvania Department of Health and by local health departments. You may secure additional information on testing and counseling from the Department of Health at 717-783-0479.

Unless precluded by law, tests may be performed to determine the presence of antibodies 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 HTLV-III—Western Blot Test Protocol helps to identify AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids *(fats)* and screening for liver or kidney disorders, diabetes and immune disorders.

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 Medical Information Bureau *(MIB, Inc.)* and if the test results for HIV antibodies are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only nonspecific blood and/or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. 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 authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. You may request notification of negative HIV test results. If the HIV test results are other than normal, the Insurer will contact the physician; Pennsylvania Department of Health; local health department; or community-based organization *(from a list prepared by the Pennsylvania Department of Health)*, whichever you designate.

Your consent may be revoked at any time except to the extent the Insurer making a disclosure has acted in reliance on your consent.

Positive HIV antibody 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 have concluded that persons who are HIV antibody-positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody test 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. However, no exclusion rider or endorsement will be applied.

I have read and I understand this Notice of Consent for Blood Testing Which May Include HIV Antibody Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood and the disclosure of the test/screening 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.

____ ____________________

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

I understand that I have the right to request and receive notification of negative HIV test results.

In the event of a positive HIV test result, I authorize Assurity Life Insurance Company to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

Name and address of physician; the Pennsylvania Department of Health; local health department; or community-based organization *(from the list prepared by the Pennsylvania Department of Health)*, whichever you designate to receive notice of a positive result:

Name ______________________________

Address ______________________________

____

______________________________ *Proposed Insured (please print)*

______________________________ *State of Residence*

______________________________ *Signature of Proposed Insured or Parent/Guardian*

______________________________ *Date (MM/DD/YYYY)*

LOCAL COMMUNITY-BASED ORGANIZATIONS

Pittsburgh AIDS Task Force
141 South Highland Avenue
Pittsburgh, PA 15206
412-363-2437

Philadelphia Community Health Alternatives
1642 Pine Street
Philadelphia, PA 19103
215-735-1911

Congreso-de Latinos Unidos, Inc.
Programa Esfurizo
704 West Girard Avenue
Philadelphia, PA 19103
215-228-3880

BEBASHI
5205 North Broad Street
Philadelphia, PA 19141
215-546-4140

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

Life Insurance or Annuity
REPLACEMENT NOTICE

NOTICE REGARDING REPLACEMENT

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy, which has been in existence for a period of time, may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could (contest the policy because of a material misrepresentation or omissions concerning the medical information requested in your application, or) deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options, which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages, which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

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

____ _______________
Agent's Signature and Printed Name (if any) *Date (MM/DD/YYYY)**

____
Agent's Address (Street Address, City, State and Zip)

INFORMATION ON POLICIES WHICH MAY BE REPLACED

COMPANY NAME	POLICY NO.	NAME OF INSURED

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

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

Life Insurance or Annuity
REPLACEMENT NOTICE

NOTICE REGARDING REPLACEMENT

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy, which has been in existence for a period of time, may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could (contest the policy because of a material misrepresentation or omissions concerning the medical information requested in your application, or) deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options, which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages, which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are canceling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

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

______________________________ ______________
Agent's Signature and Printed Name (if any) *Date (MM/DD/YYYY)**

____
Agent's Address (Street Address, City, State and Zip)

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

Assurity Life Insurance Company
1526 K Street • Box 82533
Lincoln, Nebraska 68501-2533
Telephone Toll-Free: (800) 276-7619, Ext. 4264

ILLUSTRATION DISCLOSURE STATEMENT

Proposed Insured's Knowledge and Agent's Certification of

- ☐ Application differs from illustration
- ☐ No illustration used in sales process
- ☐ Illustrations provided on computer screen

PROPOSED INSURED ACKNOWLEDGEMENT

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.

Proposed Insured's Signature	Date

AGENT CERTIFICATION

I certify that:

- An illustration matching the application for insurance was not provided at time of sale for the reason marked above (if a computer screen application was used, it was based on the following:

  Gender Age
  Underwriting Class
  Policy Type
  Initial Death Benefit
  Riders
  Assumed Interest Rate

- I explained that a conforming illustration would be produced and delivered no later than at the time of policy delivery.
- I explained that any non-guaranteed elements for the policy are subject to change.
- I have made no statements that are inconsistent with the illustration that will be produced.

Agent Signature	Date

For use with UL/SPWL policies.
Use disclosure Form 9925.

LIMITED LIFE EXPECTANCY

ACCELERATED DEATH BENEFIT RIDER

Notice: accelerated death benefits advanced under this rider may be taxable. The Owner should consult a tax advisor before requesting this benefit.

Payment of the rider benefit will reduce the amount of life insurance in force under the policy.

This rider is part of the policy to which it is attached. It is subject to all of the provisions of the policy, unless otherwise stated in this rider. The effective date of this rider is the Policy Date of the policy unless a later effective date is shown in this rider or on the policy Schedule. The Insured and Owner of this rider are the same as the Insured and Owner of the policy.

ACCELERATED DEATH BENEFIT

- TERMINAL Condition. If the Insured has a terminal condition, the Owner can ask Us to advance up to 75% of the net amount of insurance. The advance(s) may be made in a lump sum or in any way We agree.

CLAIM PROCEDURES

The Owner must send Us:

- due proof that the Insured has a terminal condition;
- a completed claim form; and
- the policy.

If, upon Our review, all conditions of payment prove to be met and the Insured has not died, We will pay the advance(s) to the Owner.

We have the right to have the Insured examined at Our cost by a physician of Our choice. If there are conflicting medical opinions between the Insured's physician and Our physician, Our physician's opinion will determine whether an advance is proper.

ADVANCE LIMITS

The maximum We will pay for all advances is $250,000. We will make no advance if the Owner is required to use this benefit to pay:

- creditors; or
- in order to get or keep governmental benefits or entitlements.

ASSIGNEE/IRREVOCABLE BENEFICIARY

The Owner must provide written consent to the payment of this benefit from any assignee and/or irrevocable beneficiary of record. Any payment made by Us in good faith prior to Our knowledge of the existence of any assignee, beneficiary, or anyone else claiming to have an interest in the benefits of this policy will discharge Our liability for the amount of such payment.

REPAYMENT

Before the Insured dies, We will accept a partial or full repayment of an advance. This payment will be applied to restoring the death benefit.

INTEREST ON ADVANCES

We will charge interest on all advances. The interest rate will be the same as the current interest rate on policy loans (see the LOAN INTEREST provision of the policy). Interest on each advance starts when the advance is made. It may be paid at any time. Interest will be compounded on an annual basis to the date of death.

BENEFIT PAYMENT NOTICE

At the time of the lump sum benefit payment or the first payment if paid in installments, We will send the Owner a written notice showing the amount of the lump sum or periodic payment benefit, and the remaining policy death benefit.

Sample

EFFECT ON THE POLICY

Payment of a benefit under this rider will not affect the policy's Surrender Value, premiums, or any policy loan balance. On the Insured's death, the balance of the death benefit, if any, will be payable to the Beneficiary.

The following is added to the "DEATH BENEFIT" provision:

We will subtract:

- the amount of all advances paid, and
- unpaid interest on those advances.

DEFINITIONS

- NET AMOUNT OF INSURANCE – the policy death benefit less the Surrender Value. This amount is based on the policy values (excluding riders) as of the first day an advance is paid. We will calculate the amount only once unless advances stop for 12 months or more.
- PHYSICIAN – A medical doctor (M.D.) or a doctor of osteopathy (D.O.), licensed in the United States and operating within the scope of his or her license.
- TERMINAL CONDITION – A terminal condition exists if the Insured has a life expectancy of 12 months or less as certified by a physician.

This rider does not affect any other policy provisions.

Carol S Watson
Secretary

President

sample

DISCLOSURE STATEMENT
ACCELERATED DEATH BENEFIT RIDER

Accelerated benefits advanced under the Accelerated Death Benefit Rider may be taxable. The Owner should consult a personal tax advisor before requesting this benefit.

Payment of the rider benefit will reduce the amount of life insurance in force under the policy.

BENEFIT

The Accelerated Death Benefit Rider allows the Owner to request the Accelerated Death Benefit as provided in the rider.

- TERMINAL CONDITION. If an Insured has a terminal condition, the Owner can ask Us to advance up to 75% of the net amount of life insurance in force under the certificate, in a lump sum or in any way We agree.

The maximum we will pay for all advances under this rider is $250,000.

INTEREST ON ADVANCES

We will charge interest on all advances. The interest rate will be the same as the current interest rate on policy loans (see the LOAN INTEREST provision of the policy). Interest on each advance starts when the advance is made. It may be paid at any time. Interest will be compounded on an annual basis to the date of death.

EFFECT ON THE POLICY

Payment of a benefit under this rider will not affect the policy's Surrender Value, premiums, or any policy loan balance. On the Insured's death, the balance of the death benefit, if any, will be payable to the Beneficiary.

NO PREMIUM CHARGE OR ADMINISTRATIVE EXPENSE CHARGES

No premium charge or administrative expense charges are associated with the rider or benefit payment(s).

I ACKNOWLEDGE RECEIPT OF THIS DISCLOSURE.

______________________________	__________	______________________________
Signature of Agent	Date	Signature of Owner

DISCLOSURE STATEMENT
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______________________________	__________	______________________________
Signature of Agent	Date	Signature of Owner

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DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

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

Age ________ ☐ Male ☐ Female

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

Agent Phone No. ( ) ____________ Agent E-mail Address ____________

Name of Insurer **Assurity Life Insurance Company**
Home Office Address of Insurer **P.O. Box 82533, Lincoln, NE 68501-2533**
Direct all correspondence to Insurer's home office.

If not applicable to insurance being offered, the section may be clearly marked "Not Applicable," and left blank.

Amount of Coverage and Benefits Offered—

	Descriptive Title of Coverage	Face Amount of Coverage *(if applicable)*	Annual Premium or Premium for Mode Quoted
Policy			
Riders			
Supplemental Benefit(s) *(built into the policy)*			Cost included in premium

Total initial ____________ premium for the policy and rider will be $ ________
Monthly, quarterly, etc.

Changes to Coverage—Please explain in detail any changes to this coverage:

____

____

Changes to Premiums—Please explain in detail any changes to premiums for this coverage:

____

____

The Proposed Insured should retain a copy of this completed form.

Retirement Income—

Your policy is designed to pay a guaranteed retirement income of $___________ starting at _________ (*Age, Year*) for _________ (*Duration*) but not for less than 10 years.

Guaranteed Cash Value—

If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each $1,000 of insurance. You may borrow against this cash value at an annual ___________percent loan interest charge.

Number of years policy has been in force	**5**	**10**	**20**	**Age 45**
Total accumulated cash value per $1,000	___________	___________	___________	___________

Dividends—

The following is a dividend illustration for your policy based on the current interest, mortality and expense experience of the company as reflected in the dividends currently paid. However, the illustrations are not a guarantee of what future dividends will be. Payment of a dividend is contingent upon the payment of the next premium due.

Number of years policy has been in force	**10**	**20**
Illustrated dividend for that individual year per $1,000 of insurance	___________	___________

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies.

The Proposed Insured ☐ has ☐ has not requested an earlier delivery of the Index.

Upon request, either the company or agent will furnish you with additional information about the insurance described.

AGENT CERTIFICATION

I hereby certify that I have provided the Proposed Insured with this Disclosure Statement required by Pennsylvania Regulation Section 83.3 *(life applications only)*.

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

The Proposed Insured should 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:

Applicant/Owner Name ____________________ Social Security No. _____ — _____ — _____

1. Source of Funds

- ☐ Current Income
- ☐ Savings
- ☐ Another person *(if so, identify)* ____________
- ☐ Proceeds of canceled life insurance policy
- ☐ From values of existing life insurance policy
- ☐ Other ____________

2. Intended purpose of applied for coverage

- ☐ 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 ____________

3. Applicant's background

- ☐ Length of time known *(in years)* ____________
- ☐ Nature of relationship ____________
- ☐ How known ____________
- ☐ Applicant's occupation ____________

Business relationship with applicant? ☐ Yes ☐ No If so, describe ____________

4. Any additional information you possess regarding the background of/your relationship with the applicant

____

____

5. Source of information

Name ____________________

☐ Applicant ☐ Owner ☐ 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 applicant, except where information from me is required.

____________________ *Producer Signature*

____________________ *Producer No.*

____________________ *Producer Name*

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

Mail or fax this completed and signed form along with the application submitted to the home office.

ASSURITY® LIFE INSURANCE COMPANY
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Automatic PREMIUM PAYMENT

Name of Proposed Insured ______________________ Date Signed ___/___/___
First *Middle* *Last* *(MM/DD/YYYY)*

Policy No. *(if for an existing policy)* ______________________

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

Name of Account Holder or Authorized Officer ______________________

☐ Initial and recurring premiums ☐ Recurring premiums only

If "Initial and recurring premiums" is marked, the company's authority to debit from your account the first premium for this insurance does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Type of Account: ☐ Checking ☐ Savings

Date of Withdrawal ________ Date ***cannot*** be the 29th, 30th or 31st. If no date is entered, the policy issue date will be used.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account listed below for premiums as selected above. I understand that initiating automatic payments may result in additional drafts to bring my account current. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account. I further understand that if the date of the withdrawal is after the policy issue date and if any premium is not honored, my policy may lapse and require evidence of insurability, according to the terms of my policy.

______________________ ______________________ ______________________
Name of Financial Institution *Routing No. (9-digit number)* *Account No.*

______________________ ___/___/___ (___)___________
Signature of Account Holder or Authorized Officer and Title *Date (MM/DD/YYYY)* *Telephone No.*

TO ENSURE CODING ACCURACY, SUBMIT VOIDED CHECK
(unless application is submitted electronically)

CREDIT CARD AUTHORIZATION

Name of Account Holder or Authorized Officer ______________________

☐ Initial premium only ☐ Recurring premiums only ☐ Initial and recurring premiums

If "Initial premium only" or "Initial and recurring premiums" is marked, the company's authority to charge the first premium for this insurance to your credit card does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Type of Card: ☐ MasterCard ☐ Visa ☐ Discover

Date of Charge: ☐ 1st ☐ 5th ☐ 10th ☐ 15th ☐ 20th ☐ 25th
If no date is selected, recurring charges will occur on the option date immediately prior to the policy issue date.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate charges to my credit card listed below for premiums as selected above. I understand that initiating automatic payments may result in additional drafts to bring my account current. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any charges to my credit card. I further understand that if the date of the withdrawal is after the policy issue date and if any premium is not honored, my policy may lapse and require evidence of insurability, according to the terms of my policy.

______________________ ______________________ ___/___
Name as it appears on Card (Please print) *Card/Account No.* *Expiration Date (MM/YYYY)*

Credit card billing address ______________________
Street Address *P.O. Box* *City* *State* *Zip+4*

______________________ ___/___/___ (___)___________
Signature of Account Holder or Authorized Officer and Title *Date (MM/DD/YYYY)* *Telephone No.*