



Toll Free: 1-800-276-7619, Ext. 4264

AssureLINK Address: <http://assurelink.assurity.com>

Arizona Application for Simplified Disability Income Insurance

This application includes all forms needed to apply for Simplified Disability Income Insurance.

Thank you for your interest in writing business with Assurity Life Insurance Company.

To enable us to process your application more quickly, please review the following checklist:

- ✓ The application should coincide with the **state where the application is signed**. State specific applications and state forms can be found on AssureLINK.
- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state coinciding with the application used**.
- ✓ On Disability applications, the Proposed Insured and the policy Owner must be the same person.
- ✓ Print the application in black ink for faxing and photo copying purposes.
- ✓ Please verify that all questions on the application are answered. 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
 1. Complete all other pertinent and applicable forms padded together in this application.
- ✓ If the Proposed Insured has a history of heart trouble, stroke, or cancer, do not collect the initial premium.
- ✓ 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 QUESTIONS RELATING TO UNDERWRITING (INCLUDING "WHAT IF" SCENARIOS) CALL TOLL FREE 800-276-7619, EXT. 4264 OR EMAIL TO underwriting@assurity.com.



PROPOSED INSURED

Legal Name <i>First Middle Last</i>			Date of Birth <i>(MM/DD/YYYY)</i> / /		
Social Security No.		<input type="checkbox"/> Male <input type="checkbox"/> Female	E-mail		Age
Home Address <i>Street Address</i>		<i>City</i>		<i>State</i>	<i>ZIP+4</i>
Personal Phone No. ()		Birth State/Country		Height ft. in.	Weight lbs.
Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If YES, please list type: _____ and last date of use <i>(MM/DD/YYYY)</i> : / /					
Is the Proposed Insured a United States citizen or does the Proposed Insured have permanent resident (<i>green card</i>) status? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number: _____					
Is the Proposed Insured currently working at least 30 hours per week in primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of employment? <i>Years Months</i> /					
Primary Employer		Employer's Address <i>Street Address City State ZIP+4</i>			
Full-time Employment <i>Occupation Duties</i>			Part-time Employment <i>Occupation Duties</i>		
Gross monthly income \$			If self-employed, net monthly income \$		

BENEFICIARY

Beneficiary Name <i>(First, Middle, Last)</i>		Relationship to Insured	Social Security No.	Date of Birth <i>(MM/DD/YYYY)</i> / /
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PREMIUM PAYMENT MODE

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

GENERAL SECTION

1. During the past **5 years** or within the next **12 months** *(If YES to any of the following, please complete and return the Avocation Questionnaire)*:

a. Has the Proposed Insured flown, or is the Proposed Insured planning to fly, as a pilot, crew member or student? Yes No

b. Has the Proposed Insured participated in, or is the Proposed Insured planning to participate in any hazardous sport or activities? Yes No

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

2. During the past **5 years**, has the Proposed Insured had their driver's license suspended or revoked, been convicted of or pleaded "guilty" or "no contest" to driving under the influence *(DUI/DWI)* or had more than 3 moving violations? Yes No

If YES, please explain: _____

3. Is the Proposed Insured currently on probation? Yes No

If YES, please list reason for probation and length of probationary period: _____

4. During the past **2 years**, has the Proposed Insured been declined for disability or life coverage? Yes No

If YES, please explain: _____

5. Is the Proposed Insured currently negotiating for other insurance coverage? Yes No

If YES, please explain: _____

6. 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.

7. Does the Proposed Insured have other disability income insurance coverage in force? If YES, please provide details below. Yes No

Company Name	Policy No.	Business (B) Personal (P)	Monthly Benefit and Benefit Period	Issue Date <i>(MM/DD/YYYY)</i>	Coordinates with Social Security?	Employer Paid?
_____	_____	<input type="checkbox"/> B <input type="checkbox"/> P	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> B <input type="checkbox"/> P	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



HEALTH SECTION

- During the past **5 years**, has the Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, any of the following:
 - Mental or nervous system disorder, depression, chest pain, or disease or disorders of the joints, muscles or spine? Yes No
 - Alcoholism, drug addiction or other substance abuse, or had a positive test for an illegal drug? Yes No
 - Any disease or disorder of the stomach, intestines, bowel, rectum, appendix, liver, pancreas, thyroid, urinary system or gallbladder? Yes No
- Has the Proposed Insured **ever** had or been advised to have an organ or tissue transplant, or consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, any of the following: disease or disorder of the heart (*including heart attack, heart condition, congestive heart failure, heart valve disorder*), circulatory system (*including peripheral vascular disease, carotid artery disease*), kidneys, liver (*excluding hepatitis A*), lungs or respiratory system (*including emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea*); Alzheimer's disease; dementia; high blood pressure; insulin dependent diabetes; Hodgkin's disease; internal cancer; leukemia; lymphoma; melanoma; multiple sclerosis (*MS*); muscular dystrophy (*MD*); systemic lupus erythematosus (*SLE*); stroke; or transient ischemic attack (*TIA or mini-stroke*)? Yes No
- Has the Proposed Insured **ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*); or had a positive test for human immunodeficiency virus (*HIV*) antibodies? Yes No
- Has the Proposed Insured been advised to have surgery, treatment or testing which has not been completed or for which results have not been received? Yes No
- Has the Proposed Insured **ever** needed assistance or personal supervision to perform any activities of daily living (*toileting, transferring, continence, eating, bathing or dressing*)? Yes No
- Is the Proposed Insured currently pregnant? If YES, date child is expected (MM/DD/YYYY) ____ / ____ / ____ Yes No
If YES, during this or any prior pregnancy, has there been a history of pregnancy-related complications? Yes No
- Is the Proposed Insured currently taking prescription medication? Yes No

8. **DETAILS:** Enter complete details from questions #1-7 below. If additional space is needed, attach a separate sheet of paper.

Question #/Letter	Date of Condition (MM/DD/YYYY)	Health Condition & Details	Prescription Medication(s)	Medical Care Provider's Name/Address/Phone
	/ /			
	/ /			
	/ /			

9. Critical Illness Benefit Rider only—Have two or more of the Proposed Insured's natural parents, brothers or sisters (*either living or deceased*) been diagnosed with the same conditions from the following list: heart disease, stroke, diabetes or the same type of cancer prior to age 55? Yes No

DISABILITY INCOME PRODUCT SECTION

- Occupation Class: 1 2
 - Elimination Period: 30 days 60 days 90 days 180 days
 - Benefit Period: 6 months 1 year 2 years
 - Monthly Base Amount (*maximum \$2,500*): \$ _____
- Additional Benefits: Critical Illness Benefit Rider \$5,000 \$10,000 Retroactive Injury Benefit Rider Return of Premium Benefit Rider

AGREEMENT

I, the Proposed Insured, agree that:

- All answers in this Application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability.
- The first premium is equal to the full premium for the Premium Payment Mode selected. If the first premium is paid on the date this Application is signed, the insurance applied for becomes effective on that date subject to: **a.** the Company's underwriting requirements, **b.** the terms of the attached Conditional Receipt, and **c.** the terms of the policy applied for.
- If the first premium is not paid on the date this Application is signed, no insurance will be in effect unless: **a.** such policy is issued, delivered to and accepted by me, and the entire first premium is paid during my lifetime, and **b.** at the time of such delivery, acceptance or payment, whichever is later, all information furnished in this Application remains true and complete to the best of my knowledge.

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.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau Inc., that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. A photographic copy of this authorization shall be as valid as the original. **I agree** this authorization shall be valid for two years from the date shown below. **I understand** that I or my authorized representative may receive a copy of this authorization.

Signed at _____ on ____ / ____ / ____ by _____
City State Date (MM/DD/YYYY) Signature of Proposed Insured

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions regarding the Proposed Insured:

- 1. a. What amount was collected with this application? \$ _____
- b. Has a Conditional Receipt been given to the Proposed Insured? Yes No
- c. Has a Fair Credit and MIB Notification been given to the Proposed Insured? Yes No
- 2. a. Did you personally see the Proposed Insured on the date of application? Yes No
- b. How well do you know the Proposed Insured? Well Slightly Not at all
- c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect their insurability? Yes No
If YES, please provide details: _____
- d. Is the Proposed Insured a citizen of the United States? If NO, provide a copy of a permanent visa—front and back. Yes No
- 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. _____ %

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

LIST BILL

- Set up NEW list bill (Complete Employer's Authorization and Case Agreement).
 - Add to existing list bill; indicate list bill no. _____
- Name of Company _____

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

- Type of Account: Checking Savings Add to existing bank withdrawal; indicate other applicant or policy numbers: _____
- NEW sign authorization below, attach voided check. Date of Withdrawal _____
Date of Withdrawal **cannot be the 29th, 30th or 31st**. If no date is entered, the policy issue date will be used.
- Initial premium only Recurring premiums only Initial and recurring premiums

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. 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.

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

DO NOT SIGN / / ()
Signature of Account Holder Date (MM/DD/YYYY) Telephone No.

CREDIT CARD AUTHORIZATION

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate charges to my credit card listed below for premiums as selected below. 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.

- Initial premium only Recurring premiums only Initial and recurring premiums
- The Company's authority to charge the initial premium to your credit card for this insurance does not begin until the date the policy is issued. The premium will not be deemed paid and no coverage will be in force until payment is initiated.**
- 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.

Name as it appears on card (Please print) Card/Account No. Expiration Date (MM/YY) _____

DO NOT SIGN / / ()
Signature of Account Holder Date (MM/DD/YYYY) Telephone No.



AssurityBalance® Simplified Disability Income Insurance (DI)

Base Policy Sample Rates

		Annual Premium per \$100 Monthly Benefit															
		6 mo./ 30-day				6 mo./ 60-day				6 mo./ 90-day				6 mo./ 180-day			
		Male		Female		Male		Female		Male		Female		Male		Female	
		Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	18-39	\$11.38	\$13.39	\$17.06	\$20.07	\$8.54	\$10.05	\$12.80	\$15.06	\$3.26	\$3.84	\$4.89	\$5.75	\$2.87	\$3.38	\$4.30	\$5.06
	40-49	17.72	20.85	24.81	29.19	14.01	16.48	19.62	23.08	7.13	8.39	9.99	11.75	6.27	7.38	8.79	10.34
	50+	26.30	30.94	28.93	34.04	22.10	26.00	24.31	28.60	14.30	16.82	15.73	18.51	12.58	14.80	13.84	16.28
Class 2	18-39	21.08	24.80	31.62	37.20	16.86	19.84	25.29	29.75	9.02	10.61	13.53	15.92	7.94	9.34	11.91	14.01
	40-49	30.68	36.09	38.35	45.12	25.05	29.47	31.32	36.85	14.60	17.18	18.25	21.47	12.85	15.12	16.06	18.89
	50+	44.20	52.00	46.41	54.60	37.55	44.18	39.43	46.39	25.20	29.65	26.46	31.13	22.18	26.09	23.28	27.39

		1 yr./ 30-day				1 yr./ 60-day				1 yr./ 90-day				1 yr./ 180-day			
		Male		Female		Male		Female		Male		Female		Male		Female	
		Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
		Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	18-39	16.61	19.54	24.92	29.32	13.03	15.33	19.54	22.99	6.37	7.49	9.56	11.25	5.61	6.60	8.41	9.89
	40-49	26.62	31.32	37.27	43.85	21.90	25.76	30.66	36.07	13.13	15.45	18.38	21.62	11.55	13.59	16.17	19.02
	50+	40.83	48.04	44.91	52.84	35.60	41.88	39.16	46.07	25.90	30.47	28.49	33.52	22.79	26.81	25.07	29.49
Class 2	18-39	30.14	35.46	45.21	53.19	25.02	29.44	37.53	44.15	15.51	18.25	23.27	27.38	13.65	16.06	20.48	24.09
	40-49	45.43	53.45	56.79	66.81	38.44	45.22	48.05	56.53	25.45	29.94	31.82	37.44	22.40	26.35	28.00	32.94
	50+	67.84	79.81	71.23	83.80	59.65	70.18	62.63	73.68	44.44	52.28	46.66	54.89	39.11	46.01	41.06	48.31

		2 yr./ 30-day				2 yr./ 60-day				2 yr./ 90-day				2 yr./ 180-day			
		Male		Female		Male		Female		Male		Female		Male		Female	
		Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
		Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	18-39	22.93	26.98	34.39	40.46	18.56	21.84	27.83	32.74	10.44	12.28	15.66	18.42	9.19	10.81	13.78	16.21
	40-49	39.02	45.91	54.63	64.27	33.08	38.92	46.32	54.49	22.06	25.95	30.88	36.33	19.41	22.84	27.17	31.96
	50+	62.63	73.68	68.89	81.05	56.13	66.04	61.74	72.64	44.06	51.84	48.46	57.01	38.77	45.61	42.64	50.16
Class 2	18-39	41.00	48.24	61.50	72.35	35.03	41.21	52.54	61.81	23.93	28.15	35.89	42.22	21.06	24.78	31.58	37.15
	40-49	65.95	77.59	82.44	96.99	57.42	67.55	71.78	84.45	41.59	48.93	51.99	61.16	36.60	43.06	45.75	53.82
	50+	103.28	121.51	108.45	127.59	93.22	109.67	97.88	115.15	74.53	87.68	78.26	92.07	65.59	77.16	68.87	81.02

Critical Illness Rider Rates

Annual Premium Rates per \$5,000 Lump Sum Benefit				
	Non-Tob.		Tob.	
	Male	Female	Male	Female
18-39	\$26.05	\$29.88	50.51	45.91
40-49	65.74	62.01	123.83	96.27
50+	144.08	106.79	267.68	176.23

Return of Premium Rider Rates

Percentage of Total Annual Premium for Base Policy and All Other Riders				
Occ Class 1 & 2, All Benefit Periods				
Elim. Period	30	60	90	180
18-39	40%	47%	53%	59%
40-49	77%	89%	101%	113%
50+	157%	172%	188%	204%

*See second page for
Retroactive Injury Rider rates
and a premium worksheet*

This policy may contain reductions of benefits, limitations and exclusions. For costs and complete details of the coverage, please contact Assurity Life Insurance Company or ask to review the policy for more information.

Policy availability, rates and features may vary by state.

FOR PRODUCER USE ONLY.

Policy Form No. I D0710
Rider Form Nos. R I0711, R I0712, R I0713

Retroactive Injury Rider Rates

Annual Premium per \$100 Monthly Benefit																
	6 mo./ 30-day				6 mo./ 60-day				6 mo./ 90-day				6 mo./ 180-day			
	Male		Female		Male		Female		Male		Female		Male		Female	
	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	\$1.27	\$1.49	\$1.90	\$2.24	\$1.20	\$1.41	\$1.80	\$2.12	\$1.07	\$1.26	\$1.60	\$1.88	\$0.94	\$1.11	\$1.41	\$1.66
Class 2	2.93	3.45	3.81	4.48	3.11	3.66	4.04	4.75	3.45	4.06	4.48	5.27	3.04	3.58	3.94	4.64

	1 yr./ 30-day				1 yr./ 60-day				1 yr./ 90-day				1 yr./ 180-day			
	Male		Female		Male		Female		Male		Female		Male		Female	
	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	1.23	1.45	1.85	2.18	1.16	1.36	1.75	2.06	1.04	1.22	1.56	1.84	0.92	1.08	1.37	1.61
Class 2	2.85	3.35	3.71	4.36	3.03	3.56	3.94	4.64	3.36	3.95	4.36	5.13	2.96	3.48	3.84	4.52

	2 yr./ 30-day				2 yr./ 60-day				2 yr./ 90-day				2 yr./ 180-day			
	Male		Female		Male		Female		Male		Female		Male		Female	
	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.	Non-Tob.	Tob.
Class 1	1.20	1.41	1.80	2.12	1.13	1.33	1.70	2.00	1.01	1.19	1.52	1.79	0.89	1.05	1.34	1.58
Class 2	2.78	3.27	3.61	4.25	2.95	3.47	3.83	4.51	3.27	3.85	4.25	5.00	2.88	3.39	3.74	4.40

Sample Premium Calculation

Male, age 20 – Class 1 – Non-Tob. – \$1,000 – 2 yr./ 30-day Benefit							
Base Benefit	\$22.93 (Base Rate)	x	10 (# of 100s of Base)	=	\$229.30	BASE PREMIUM	
	\$229.30 (Base Premium)	+	\$40 (Policy Fee)	=	\$269.30	x 0.088 (Modal Factor*) = \$23.70	
Retroactive Injury Benefit Rider (RIB)	\$1.20 (RIB Rate)	x	10 (# of 100s of Base)	=	\$12	x 0.088 (Modal Factor*) = \$1.06	
Critical Illness Rider	\$26.05 (CI Rate)	x	2 (# of 5000s)	=	\$52.10	x 0.088 (Modal Factor*) = \$4.58	
SUBTOTAL	(Sum of all the premiums in the right-most column)					=	\$29.34 SUBTOTAL PREMIUM
Return of Premium Rider	40% (Percent)	x	\$29.34 (Subtotal Premium)	=	\$11.74	ROP RIDER PREMIUM	
Total Modal Premium	(Sum of Subtotal Premium and ROP Rider Premium)					=	\$41.08

* Modal Factors: Annual = 1.000; Semi-annual = 0.510; Quarterly = 0.264; Monthly = 0.088

Your Premium Calculation

Male or Female – Age: ____ – Class 1 or 2 – Non-Tob. or Tob. – Amount: _____ – Benefit: _____							
Base Benefit	\$ (Base Rate)	x	 (# of 100s of Base)	=	\$	BASE PREMIUM	
	\$ (Base Premium)	+	\$40 (Policy Fee)	=	\$	x (Modal Factor*) = \$	
Retroactive Injury Benefit Rider (RIB)	\$ (RIB Rate)	x	 (# of 100s of Base)	=	\$	x (Modal Factor*) = \$	
Critical Illness Rider	\$ (CI Rate)	x	 (# of 5000s)	=	\$	x (Modal Factor*) = \$	
SUBTOTAL	(Sum of all the premiums in the right-most column)					=	\$ SUBTOTAL PREMIUM
Return of Premium Rider	% (Percent)	x	\$ (Subtotal Premium)	=	\$	ROP RIDER PREMIUM	
Total Modal Premium	(Sum of Subtotal Premium and ROP Rider Premium)					=	\$



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)





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.



Conditional Receipt

including notices required by the
Fair Credit Reporting Act
and the
Medical Information Bureau (MIB)

The following Conditional Receipt is issued by Assurity Life Insurance Company when the full initial premium is collected from the Proposed Insured/Owner at the time the application is completed. The full initial premium may be collected when the amount of in-force and applied for individual life coverage, including the present value of future benefits of any reversionary annuity policy, with Assurity Life Insurance Company does not exceed \$500,000. This \$500,000 limit applies to applications on which the Proposed Insured has fully and accurately answered all health questions indicating no significant health problems. Individual life applications may be accepted without the health questions answered if the Proposed Insured is to be medically examined. However, in these cases, the full initial premium can be collected only when the in-force and applied for coverage, including the present value of future benefits of any reversionary annuity policy, does not exceed \$100,000 with Assurity Life Insurance Company. The full initial premium may also be collected for individual disability coverage when the amount of in-force and applied for individual disability coverage (base policy Monthly Benefits plus SDIR Monthly Benefit) with Assurity Life Insurance Company does not exceed \$2,500 per month. Applications with in-force and applied for amounts that exceed these limits, or where the Proposed Insured has significant health problems, must be handled on a Cash On Delivery (C.O.D.) basis.

In addition to the above insurance limits, issuing a Conditional Receipt requires **full modal payment** (including PAC authorization and sample check for PAC mode, if applicable). A Conditional Receipt may **not** be issued in exchange for a postdated check or a partial premium payment. **Payment in this manner in no way conditionally binds Assurity Life Insurance Company.**

Following the Conditional Receipt are two notices required to be given to the Proposed Insured. The federal **Fair Credit Reporting Act** notice explains the nature of investigative consumer reports, and explains the Proposed Insured's rights if such a report is requested. The disclosure regarding the **Medical Information Bureau (MIB)** informs the Proposed Insured of restrictions on obtaining and disclosing confidential medical information.

Conditional Receipt

Assurity Life Insurance Company • Lincoln, Nebraska

The Proposed Insured/Owner's payment of the full initial premium and acceptance of this Conditional Receipt constitutes the Proposed Insured/Owner's acceptance of its terms and conditions. Unless all terms and conditions are fulfilled exactly, no insurance will become effective prior to policy delivery. In all events, any insurance provided is subject to the stated limits. No agent is authorized to change or waive any conditions or limits. Please make **all** premium checks payable to "Assurity Life Insurance Company". Please **do not** make checks payable to the agent or leave "payee" blank.

1. The sum of \$_____ is received of _____ by Assurity Life Insurance Company ("The Company") as payment of the full initial premium on insurance applied for on this date. Payment is accepted subject to the terms and limitations of this Conditional Receipt ("Receipt"). It is expressly understood and agreed that unless all conditions set forth in this Receipt are satisfied, or that unless the coverage applied for is issued within 60 days of the date of application, no insurance shall ever take effect. In such case, the Company's only liability and obligation is to promptly refund the premium payment received.
2. If, on the applicable date, the Proposed Insured was acceptable for the plan and amount of insurance applied for, without modification, under Assurity's rules, limits and standards of insurability, coverage will be effective the later of i) the date of application, or ii) the date any medical examination of the Proposed Insured is completed, if required by the Company. Insurance will be issued at Assurity's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.
- 3a. Assurity Life Insurance Company has NO liability for life insurance coverage if the answers to the health questions on the application indicate any significant health problems. Otherwise, the Company's total life insurance liability, including the present value of future benefits for any reversionary annuity policy, for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company, including the present value of future benefits for any reversionary annuity policy, on the Proposed Insured's behalf (including that for which this Receipt is given) shall not exceed \$500,000 if all application health questions are answered, and shall not exceed \$100,000 if no application health questions are answered.
- b. Assurity Life Insurance Company has NO liability for health insurance coverage and this Receipt is void for any insurance if any health questions on the application have not been answered and no medical examination is required of the Proposed Insured. Otherwise, the Company's total health insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that which this Receipt is given) shall not exceed \$2,500 per month.

These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.
4. This Receipt must not be detached and used unless the full amount of the first premium is paid on the date of the application. Payment cannot be accepted with the application if any person proposed for coverage has been treated for or had any known heart trouble, stroke or cancer within the past twelve months. This Receipt is void if exchanged for any check or draft that is not honored upon first presentation for collection through usual banking facilities.

Dated: _____

Agent: _____

ASSURITY LIFE INSURANCE COMPANY

1526 K Street • PO Box 82533

Lincoln, NE 68501-2533

Toll Free 800-276-7619

Employer's Authorization and Case Agreement

EMPLOYER DATA:

Name of firm ("Company") _____ Contact Person: _____

Address: _____ Telephone: _____

City: _____ State: _____ ZIP Code: _____

Nature of Business: _____

Age of Business: _____ Total number of Employees: _____ Number of Eligible Employees: _____

SIC Code of Firm: _____ Annual Average Turnover: _____ % Internet Address _____

PAYROLL INFORMATION:

Date of first payroll deduction: _____ Anticipated policy effective date: _____

BILLING FREQUENCY (Check one)	BILLING INSTRUCTIONS	BILLING SEQUENCE (Check one)
<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual <input type="checkbox"/> _____	<input type="checkbox"/> Bill for pending applications <input type="checkbox"/> Bill issued policies only	<input type="checkbox"/> Alphabetical <input type="checkbox"/> Social Security Number <input type="checkbox"/> _____

BILLING CONTACT AND TELEPHONE NUMBER: _____

SPECIAL INSTRUCTIONS: _____

AUTHORIZATION

To: Assurity Life Insurance Company

We agree to authorize a voluntary payroll deduction plan under which our company will honor requests made by employees to pay premiums on policies issued by you. The company agrees to systematically deduct such payments and forward them promptly upon receipt of your payroll deduction premium billing.

Our company may terminate the payroll deduction plan at any time by written notice. We also understand that any employee may voluntarily elect to discontinue participation in this plan and notify us to discontinue his/her payroll deductions.

Our company is under no obligation in connection with the insurance policies except for the payment of premiums which have been payroll deducted. Our responsibility for any particular employee will cease upon an employee's termination of employment. We will notify you of the termination of any participating employee.

Name and Title of Authorizing Officer (Printed): _____

Signature of Authorizing Officer: _____ Date of Signature: _____

Agent's Signature: _____ Agent's Number: _____

HOME OFFICE USE ONLY:	Agent Number: _____	Case Number: _____	Due Day/Due Code: _____
	Effective Date: _____	Number of Insureds: _____	Home Office Approval Date: _____