



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

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

## California Application for Disability Income Insurance

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

This application does not include the Life or Critical Illness section(s).

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

**You may write a Life or Critical Illness application\* in combination with this Disability Income application. In addition to this application, simply complete the appropriate Life or Critical Illness section(s) obtained from AssureLINK or from a Life or Critical Illness application. The advantages of writing a combined application are:**

- answer medical questions once
- reviewed by Underwriting once
- scheduling one medical exam
- achieve two/three sales with one visit

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

- ✓ For Disability Income and Critical Illness products, the application should coincide with the **state in which the policy Owner resides** for the states listed below. (For Disability applications, the Proposed Insured and the policy Owner must be the same person.)

Disability Income (Form A-D109): CA, FL

Simplified Critical Illness (Form CI 005): AR, CO, FL, ID, ME, MN, MT, NH, NC, ND, OK, PA, UT, WV

Critical Illness (Form CI 007): AR, ID, ME, MT, NC, ND, OK, PA, UT, WV

All other applications 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**.
- ✓ Print the application in black ink for faxing and photocopying 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. NAIC Model Illustration or disclosure statement must accompany any whole life application.
  2. Complete all other pertinent and applicable forms padded together in this application.

If faxing an application directly to the Home Office, fax to (877) 864-6630.

- ✓ If mailing directly to the Home Office, address to:  
**Assurity Life Insurance Company**  
Attn: New Business Unit  
PO Box 82533  
Lincoln NE 68501-2533

**TO CHECK THE STATUS OF AN APPLICATION, ASK QUESTIONS RELATING TO UNDERWRITING (INCLUDING "WHAT IF" SCENARIOS) CALL TOLL FREE 800-276-7619, EXT. 4264 OR EMAIL TO [underwriting@assurity.com](mailto:underwriting@assurity.com).**



**PART I – General Section (Cont.)** If medical exam required due to age and/or amount, you may omit answering questions 14-18 on Proposed Insured.

13. Names of dependent children (who have not reached their 19<sup>th</sup> birthday) proposed for Children's Term Insurance Rider. **(Note: Please complete 14-16 for any children to be covered.)**

Full Name	Relationship	Birthdate	Age	Height	Weight lbs.	Residing w/ Insured	Name/Address of Physician
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	

14. Have any persons to be covered ever been treated for, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following? *If "yes", complete #15 below.*

- A. Dizziness, fainting spells, epilepsy, depression, anxiety, mental disorder, or any disease or disorder of the brain or nervous system? .....  Yes  No
- B. Asthma, bronchitis, tuberculosis, pneumocystis, or any disorder of the lungs or respiratory system? .....  Yes  No
- C. High blood pressure, chest pain, shortness of breath, heart murmur, rheumatic fever or any disease or disorder of the heart, hemophilia or coagulation disorder? .....  Yes  No
- D. Any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder? .....  Yes  No
- E. Any disease or disorder of the kidney, bladder or prostate? .....  Yes  No
- F. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles? .....  Yes  No
- G. Diabetes, or sugar, albumin or blood in the urine? .....  Yes  No
- H. Cancer or a tumor or cyst of any kind, or enlargement of lymph nodes? .....  Yes  No
- I. Varicose veins, varicose ulcer or phlebitis, syphilis, or a hernia? .....  Yes  No
- J. Any disease or disorder of the eyes, ears, nose or throat? .....  Yes  No
- K. Any advice or treatment for alcoholism, drug addiction, drug abuse or other substance abuse? .....  Yes  No
- L. Any immune deficiency disorder, AIDS or the AIDS Related Complex (ARC)?.....  Yes  No
- M. Any other illness or injury requiring blood transfusion or other medical attention? .....  Yes  No
- N. Any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests other than AIDS related blood tests, or urine tests during the past 5 years? .....  Yes  No

15. If any questions in 14 are answered "yes," indicate the question number and give complete details.

No.	Name of Person	Condition	Onset Date	Duration	Names, Addresses and Phone #'s of all Physicians, Hospitals and Medical Facilities

16. Name, address, phone and fax # of Proposed Insured's regular physician:  Fax: Phone:	Date last consulted:
	Reasons and results:

17. Family History: Has any of your immediate family members (parents, brothers, or sisters) died from cancer, diabetes or cardiovascular disease prior to age 60?.....  Yes  No  
 If "yes," identify family member, disorder, and age at death below:

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18. A. Has any person to be insured had any disorder of any genital or reproductive organ; or a miscarriage, stillbirth or Cesarean section?.....  Yes  No  
 B. Is any person to be insured now pregnant? If "yes," give date child is expected: \_\_\_\_\_  Yes  No

**PART I – DISABILITY SECTION**

21. If the Proposed Insured were to become disabled, what amount of income or benefits would be received from: **1) Individual Disability Income Policy, 2) Sick Pay Plan and Salary Continuation Plans, 3) Group Long and Short Term Disability Coverage, 4) Business Overhead Expense, 5) Disability benefits under a life insurance policy.**  
**If “None,” so state.**

Company or Source	Type 1-5 (above)	Monthly Amount	Elimination Period	Benefit Period	Coordinates with Social Security?	Employer Paid?
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

22. Disability Plan \_\_\_\_\_

Monthly Income Base Amount \$ \_\_\_\_\_ Occupation Class \_\_\_\_\_  Tobacco  Non-Tobacco

Elimination Period:  60  90  180  365 Days Benefit Period:  1 year  2 years  5 years

**OPTIONAL BENEFITS/RIDERS**

Recovery Benefit  Return of Premium Supplemental Disability Income \$ \_\_\_\_\_  
 Elimination Period:  60  90  180  365 Days  
 Automatic Increase  Other \_\_\_\_\_

23. Who should receive Survivor Benefits? Name \_\_\_\_\_ Relationship \_\_\_\_\_

24. How shall premiums be payable?  Annually  Semi-annually  Quarterly  PAC  Other \_\_\_\_\_

**I AGREE THAT**

- A. I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree that this application (Part I—General Section, pages 1 and 2 and Part I—Disability Section, page 4; and Part II — Medical if required) shall form a part of the policy if attached thereto.
- B. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Conditional Receipt delivered by the Company’s agent in exchange for such payment.
- C. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless the application is approved by the Company at its Home Office, such policy issued and delivered to Proposed Insured/Owner, and such first full premium paid during the Proposed Insured’s lifetime and continued good health, and when such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- D. No agent or medical examiner has power or is authorized to change or waive any term, provision or condition of this application, the Conditional Receipt, or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_.

Witnessed by \_\_\_\_\_  
 Licensed Resident Agent Signature of Proposed Insured

Agency No \_\_\_\_\_

## Field Underwriter's Statement

1. A. What amount was collected with this application? \$ \_\_\_\_\_
- B. Has a Conditional Receipt been given to the Proposed Insured/Owner?.....  Yes  No
- C. Has an Authorization for Release of Medical Information been signed and Fair Credit and M.I.B. notification been given?.....  Yes  No
2. A. Did you personally see all persons to be insured on date of application?.....  Yes  No  
If "No," please explain in #7.
- B. How well do you know Proposed Insured?  Well  Slightly  Relative  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?.....  Yes  No  
If "Yes," please explain in #7.
- D. Is the Proposed Insured a citizen of the United States?.....  Yes  No  
If "No," provide type of visa, number, and expiration date below:

3. Is application being submitted on a non-medical basis?.....  Yes  No  
If "No," check items for which arrangements have been made:
- Medical exam by physician with Home Office specimen  Blood Profile  EKG  Chest X-ray
- Paramedical examination with Home Office specimen\*  Dried Blood Profile  Blood Profile  EKG
- \*Preferred Plus and Preferred underwriting classifications require blood profile, not dried blood spot.

Name and address of examiner \_\_\_\_\_  
Date above items to be completed \_\_\_\_\_

4. All Life cases require a signed illustration be submitted with the application or a signed Illustration Disclosure Statement. The Premiums for this application were quoted on the following underwriting classification:
- Preferred Plus  Preferred  Select (standard, non-tobacco)  Tobacco
5. If this insurance is issued, will it replace any insurance, annuity or other policy?.....  Yes  No  
If "Yes," please explain in #7.

6. 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.

\_\_\_\_\_ Date \_\_\_\_\_ Year \_\_\_\_\_  
Soliciting Agent Signature Code No.

\_\_\_\_\_ Agent Business Phone # Agent Fax #  
Soliciting Agent Printed Name

7. Special requests, remarks and instructions:

**Was this application faxed to the Home Office?**  Yes  No  
**If yes, date faxed** \_\_\_\_\_

8. **Referrals** Name: \_\_\_\_\_  
Name: \_\_\_\_\_

9. Pre-Authorized Check (PAC)  Special monthly rate is 8.8% of annual premium.  
 New PAC  Signed authorization and deposit ticket needed with application. Applications and/or policy numbers \_\_\_\_\_ to be included on this PAC.

Add to existing PAC on: \_\_\_\_\_

List Billing  Set up new list billing—complete Employer's Authorization and Case Agreement (form VBDIEA-97)  
 List Billing  Add to existing billing # \_\_\_\_\_ to: Name of Company \_\_\_\_\_

*For Home Office use only:* Date received \_\_\_\_\_ Policy # \_\_\_\_\_ CWA \$ \_\_\_\_\_



\_\_\_\_\_  
*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, employer or medical 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, employer or medical 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](http://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 with Assurity Life Insurance does not exceed \$250,000. This \$250,000 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 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 Benefit plus SIDR 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 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 the Parent Company or Subsidiary 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 the Company in 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 the Company'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 the Company's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.
  
- 3a. The Company has NO liability for life insurance coverage if the answers to the health question on the application indicate any significant health problems. Otherwise, the Company's total life 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 for which this Receipt is given) shall not exceed \$250,000 if all application health questions are answered, and shall not exceed \$100,000 if no application health questions are answered.
  
- b. The 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 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: \_\_\_\_\_



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

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

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

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

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

**TESTS TO BE PERFORMED**

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

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

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

**MEANING OF POSITIVE TEST RESULTS**

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

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

**CONFIDENTIALITY OF TEST RESULTS**

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

**COST OF TESTING**

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

**NOTIFICATION OF TEST RESULTS**

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



**TIME LIMIT**

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

**CONSENT**

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

In the event of a positive HIV test result, I authorize Assurity Life to send the test results to the following health care professional:

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_

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

\_\_\_\_\_  
*Proposed Insured (Printed)* \_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

\_\_\_\_\_  
*Signature of Proposed Insured or Parent/Guardian* \_\_\_\_\_  
*Date (MM/DD/YYYY)* \_\_\_\_\_  
*State of Residence*



## COUNSELING RESOURCES LIST

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

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

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

AIDS HOTLINE-U.S. PUBLIC HEALTH SERVICE  
800-342-AIDS

SPANISH AIDS HOTLINE  
808-344-7432

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

SANTA CLARA COUNTY ARIS PROJECT  
Campbell  
408-370-3272

AIDS HOTLINE-SOUTHERN CALIFORNIA  
800-922-AIDS

SONOMA COUNTY AIDS INFORMATION HOTLINE  
707-579-AIDS

KERN COUNTY AIDS TEAM  
Bakersfield  
805-861-3631

AIDS PROJECT-EAST BAY  
Oakland  
415-420-8181

SACRAMENTO AIDS FOUNDATION  
Sacramento  
916-448-2437

CENTRAL VALLEY AIDS TEAM  
Fresno  
209-264-2436

SAN FRANCISCO AIDS FOUNDATION  
San Francisco  
415-846-5855

AIDS SERVICES FOUNDATION OF ORANGE COUNTY  
Costa Mesa  
714-646-0411

AIDS PROJECT-LOS ANGELES  
West Hollywood  
213-876-8951

INLAND AIDS PROJECT  
Riverside/San Bernardino Counties  
714-784-2437

SAN DIEGO AIDS PROJECT  
619-543-0300-City of San Diego  
619-945-6000-City of Vista

SANTA BARBARA COUNTY AIDS HOTLINE  
805-965-2925

CALIFORNIA DEPARTMENT OF HEALTH SERVICES  
Statewide Services  
Office of AIDS-Sacramento  
916-323-7415

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

SHASTA COUNTY HELPLINE  
916-225-5252



