



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

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

Nevada 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.



1. 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 City State 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 \$			

2. POLICYOWNER (Policyowner is the Proposed Insured unless otherwise indicated)

If Ownership is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

Legal Name <i>First Middle Last</i>			Date of Birth <i>(MM/DD/YYYY)</i> / /	
Social Security No.	Relationship to Insured	Birth State/Country		
Home Address <i>Street Address City State ZIP+4</i>	E-mail Address			
Contingent Owner's Name <i>First Middle Last</i>	Contingent Owner's Relationship to Insured			

3. BENEFICIARIES (Do not complete if applying for Reversionary Annuity or Disability Income coverage)

If Beneficiary is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

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

4. PREMIUM PAYMENT MODE

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

Payor Name <i>First Middle Last</i>	Billing Address <i>Street Address City State ZIP+4</i>
Secondary Payor Info. <i>First Middle Last</i>	Billing Address <i>Street Address City State ZIP+4</i>



5. PROPOSED JOINT INSURED											
Legal Name			<i>First</i>		<i>Middle</i>		<i>Last</i>		Date of Birth		
									(MM/DD/YYYY) / /		
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 (MM/DD/YYYY) / /											
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 _____ / _____ <small>Years Months</small>											
Primary Employer			Employer's Address		<i>Street Address</i>		<i>City</i>		<i>State</i> <i>ZIP+4</i>		
Full-time Employment			<i>Occupation</i> <i>Duties</i>		Part-time Employment			<i>Occupation</i> <i>Duties</i>			
Gross monthly income \$					If self-employed, net monthly income \$						



GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? Yes No
 If YES, please explain: _____

2. 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 any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured contemplating flying as a pilot, crew member or student? Yes No

b. Has any Proposed Insured participated in, or contemplated participation 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

3. During the next **12 months**, does any Proposed Insured contemplate residence or travel outside of the United States? Yes No
 If YES, please explain: _____

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? Yes No
 If YES, please list Proposed Insured's name, amount of weight change and reason for change:

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

a. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined, or had insurance renewal or reinstatement refused? Yes No
 If YES, please explain: _____

b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? Yes No
 If YES, please explain: _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? Yes No
 If YES, please explain: _____

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

a. Had their driver's license suspended or revoked, been convicted of or 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: _____

b. Been convicted of a felony? Yes No
 If YES, please explain: _____

8. Is any Proposed Insured currently on probation? Yes No
 If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

9. 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.

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

Company Name	Policy No.	Individual (I) Group (G)	Benefits (monthly benefit and benefit period for DI or face amount for Life)	Issue Date (MM/DD/YYYY)	DI Coverage Only	
					Coordinates w/ Soc. Sec.?	Employer Paid?
_____	_____	<input type="checkbox"/> I <input type="checkbox"/> G	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> I <input type="checkbox"/> G	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> I <input type="checkbox"/> G	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 2.

1.	Has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following: a. Heart disorder, including a heart attack (<i>myocardial infarction</i>), angina, irregular heartbeat or abnormal heart rhythm (<i>arrhythmia</i>), chest pain, hypertension (<i>high blood pressure</i>), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (<i>TIA or mini-stroke</i>), or rheumatic fever? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease (<i>other than kidney stones</i>), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (<i>including Down's syndrome</i>), multiple sclerosis (<i>MS</i>), muscular dystrophy (<i>MD</i>), Parkinson's disease, amyotrophic lateral sclerosis (<i>ALS</i>), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (<i>COPD</i>), shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (<i>lupus or scleroderma</i>)? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? <input type="checkbox"/> Yes <input type="checkbox"/> No h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No i. Any disease or disorder of the eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No j. Any other illness or injury requiring medical attention or blood transfusions? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	During the past 5 years , has any Proposed Insured: a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?..... <input type="checkbox"/> Yes <input type="checkbox"/> No b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Been advised to have any test (<i>except HIV tests</i>), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received?..... <input type="checkbox"/> Yes <input type="checkbox"/> No e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (<i>other than AIDS-related blood tests</i>) or urine tests? <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has any Proposed Insured ever been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (<i>AIDS</i>), AIDS-related complex (<i>ARC</i>) or antibodies to human T-lymphotropic virus type III (<i>HTLV</i>); or had a positive test for human immunodeficiency virus (<i>HIV</i>) antibodies? <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death. <input type="checkbox"/> Yes <input type="checkbox"/> No _____
5.	a. Has any Proposed Insured ever had any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Is any Proposed Insured currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, date child is expected (<i>MM/DD/YYYY</i>) _____ / _____ / _____

DETAILS: Enter complete details from questions #1-5 on page 2. If more space is needed, attach additional Supplemental Information form.



SUPPLEMENTAL INFORMATION

Question #/Letter	Name (First, Middle, Last)	Onset Date (MM/DD/YYYY)	Duration (Days, Mos, Yrs)	Health Condition and Details	Medical Care Provider's Name/Address/Phone
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Additional Information:

Home Office Use Only



DISABILITY INCOME PRODUCT SECTION

If additional space is needed, please attach a separate sheet of paper.

PERSONAL DISABILITY INCOME

Monthly Base Amount \$ _____ Occupation Class: 4 A 3 A 2 A 1 A

Elimination Period: 30 days 60 days 90 days 180 days 365 days

Benefit Period: 1 Year 2 Years 5 Years To age 65

Person to receive Survivor Benefits Name _____
First *Middle* *Last*

Relationship to Insured _____ Date of Birth ____/____/____ (MM/DD/YYYY)

ADDITIONAL BENEFITS (If available)

Check benefit(s) desired and indicate amount requested.

- | | | |
|---|---|--|
| <input type="checkbox"/> Supplemental Disability Income Rider \$ _____ | <input type="checkbox"/> Guaranteed Insurability Rider | <input type="checkbox"/> Hospital Benefit Rider |
| <input type="checkbox"/> Critical Illness Benefit Rider \$ _____ | <input type="checkbox"/> Automatic Benefit Increase Rider | <input type="checkbox"/> Residual Benefit Rider |
| <input type="checkbox"/> Other (Specify) _____ \$ _____ | <input type="checkbox"/> Retroactive Injury Benefit Rider | <input type="checkbox"/> 5-Year Own Occupation Rider |
| <input type="checkbox"/> Other (Specify) _____ \$ _____ | <input type="checkbox"/> Return of Premium Rider | <input type="checkbox"/> Non-Cancelable Rider |
| <input type="checkbox"/> Catastrophic Disability Income Rider (Select desired Benefit Period for Catastrophic Disability Income Rider.) | | |

Available with 1-Year Base Benefit Period: 4-Year Rider Benefit Period OR 9-Year Rider Benefit Period

Available with 2-Year Base Benefit Period: 3-Year Rider Benefit Period OR 8-Year Rider Benefit Period

Available with 5-Year Base Benefit Period: 5-Year Rider Benefit Period

BUSINESS OVERHEAD EXPENSE DISABILITY INCOME

Monthly Base Amount \$ _____ Occupation Class: 4 A 3 A 2 A

Elimination Period: 30 days 60 days 90 days

Benefit Period: 1 Year 2 Years

Person to receive Survivor Benefits Name _____
First *Middle* *Last*

Relationship to Insured _____ Date of Birth ____/____/____ (MM/DD/YYYY)

Average monthly expenses currently incurred, for which the Proposed Insured is liable:

Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
Employees' salaries	\$ _____	Accounting fees	\$ _____
Utilities (electricity, gas, water, telephone)	\$ _____	Property/payroll taxes	\$ _____
Business space (rent/mortgage payment)	\$ _____	Other eligible expenses (Please list)	_____
Furniture/equipment payments (lease or principal)	\$ _____		\$ _____
Laundry, office maintenance	\$ _____		\$ _____
Business insurance premiums	\$ _____		\$ _____
		Total Monthly Expenses	\$ _____



PRIMARY PHYSICIAN INFORMATION

Name _____
First Middle Last

Address _____
Street Address Suite

_____ *City State ZIP+4*

Phone No. () _____ Fax No. () _____

Date last consulted (MM/DD/YYYY) ____ / ____ / ____ Reason for consultation _____

Results _____

AGREEMENT

I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief. I (We) agree that this application shall form a part of the policy if attached thereto.

I (We) agree that:

- a. In the event the 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.
- b. 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: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Conditional Receipt or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

I acknowledge that I was provided an Outline of Coverage at the time this application for insurance was taken.

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 shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Substitute Form W-9 information (Request for Taxpayer Identification Number and Certification): I, the Owner (or each Joint Owner), certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____ on ____ / ____ / ____
City State Date (MM/DD/YYYY)

Signature of Proposed Insured

Signature of Additional Proposed Insured

Signature of Additional Proposed Insured

Signature of Parent/Guardian of Minor Child

Signature of Owner(s) (If other than Proposed Insured)

Signature of Beneficiary (If applying for Reversionary Annuity)

Signature of Licensed Agent

Print Agent Name and Agent No.



FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

- 1. a. What amount was collected with this application? \$ _____
b. Has a Conditional Receipt been given to the Policyowner? ... Yes No
c. 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 date of application? ... 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(s) a citizen of the United States? If NO, provide a copy of a permanent visa—front and back. ... Yes No
3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ... Yes No
4. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ... Yes No
5. 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

FOR TERM LIFE APPLICATION

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

FOR WHOLE LIFE APPLICATION

All LifeScape® Whole Life cases require that either a signed illustration or a signed Illustration Disclosure Statement be submitted with the application.
The premiums for this application were quoted on the following underwriting classification:
Preferred + Preferred Select NT Tobacco

FOR UNIVERSAL LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:
Preferred + Preferred Select NT Preferred T Standard T

FOR REVERSIONARY ANNUITY APPLICATION

All cases require that either a signed illustration or a signed Illustration Disclosure Statement be submitted with the application.
The premiums for this application were quoted on the following underwriting classification: Preferred NT Standard NT Tobacco

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





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: _____



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.

Tests may be performed to determine the presence of antibodies or antigen 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 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 in the underwriting and claims review process. Your test results will not be disclosed to your agent or broker. If the HIV test is positive, the results will be reported to the local health department or the State Department of Health, and if the insurer is a member of the Medical Information Bureau (*MIB, Inc.*) the Insurer may report the results in a generic code which signifies only nonspecific blood abnormalities. 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. If the HIV test results are other than normal, the Insurer or your designated physician will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the 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 have concluded 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.

I have read and I understand this Notice of Consent for Blood Testing Which May 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 Insurance to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

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



ASSURITY LIFE INSURANCE COMPANY

Administrative Office
1526 K Street, P. O. Box 82533
Lincoln, Nebraska 68501-2533
Telephone Toll-Free (800) 869-0355

OUTLINE OF COVERAGE

BUSINESS OVERHEAD EXPENSE DISABILITY INCOME POLICY

FORM NO. A-D 106

Prepared for: _____

Prepared by: _____

Date: _____

"We" are Assurity Life Insurance Company, the insurance company providing this Outline of Coverage. Our address is 1526 K Street, P.O. Box 82533, Lincoln, Nebraska 68501-2533. The address of Our Administrative Office and toll free telephone number appears above. We are required to notify You of the following:

1. **THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED. CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**
2. **FURTHER PROVISIONS AS TO BENEFITS, LIMITATIONS AND EXCLUSIONS ARE CONTAINED IN THE POLICY. CAPITALIZED TERMS PRINTED IN BOLD TYPE ARE USED AS DEFINED IN THE POLICY.**
3. **RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.**
4. **READ YOUR POLICY CAREFULLY.** This Outline of Coverage provides a very brief description of the important features of **Your Policy**. This is not the insurance contract; only the actual **Policy** provisions will control. The **Policy** itself sets forth in detail both **Your** rights and obligations and **Our** rights and obligations as **Your** insurance company. It is therefore very important that **You READ YOUR POLICY CAREFULLY!**
5. **DISABILITY INCOME COVERAGE** is designed to provide **You** with loss of income coverage for disabilities resulting from a covered **Injury** or **Sickness**, subject to any limitations stated in the **Policy**. Coverage is not provided for basic hospital, medical-surgical, or major medical expenses. The following pages summarize the benefits, limitations, conditions and costs of disability income coverage.

Countersigned: _____ Date: _____

POLICY BENEFITS

TOTAL DISABILITY. The **Business Overhead Expense Disability Income Policy** pays a **Monthly Overhead Expense Benefit** for each month of **Total Disability**. **Total Disability**

- is an **Injury** or **Sickness** which starts while **Your Policy** is in force;
- requires a **Physician's** care unless **We** agree such care would not help **You**;
- keeps **You** from doing the important, substantial and material duties of **Your** own occupation.

An **Injury** is an accidental bodily injury that happens while this **Policy** is in force.

A **Sickness** is an illness, disease or condition which **Originates** after the **Issue Date**.

Payment of the **Monthly Overhead Expense Benefit** begins with the first day of **Total Disability** following the **Elimination Period** and continues through the **Total Disability** until the **Maximum Overhead Expense Benefit** is reached. **Monthly Overhead Expense Benefits** will not be paid past age 65 unless

- the **Total Disability** starts after age 63 (the **Maximum Overhead Expense Benefit** is then **24 Monthly Overhead Expense Benefits**); or
- the **Policy** is renewed past age 65 (The **Maximum Overhead Expense Benefit** is then **12 Monthly Overhead Expense Benefits**).

Payment of **Renewal Premiums** is waived (or refunded) during **Total Disability** starting after the 90th day of **Total Disability**. Any **Renewal Premium** waiver stops when **Total Disability** stops or when **We** have paid the **Maximum Overhead Expense Benefit**, whichever is first.

PARTIAL DISABILITY. **We** pay 50% of the **Monthly Overhead Expense Benefit** if **You** are **Partially Disabled**. **Partial Disability** is a **Sickness** or **Injury** which keeps **You** from being **Employed on a Full-Time Basis**. **Partial Disability** must immediately follow a period of **Total Disability** for which **Monthly Overhead Expense Benefits** were paid. The **Partial Disability** period starts when **You** resume part-time employment after a paid period of **Total Disability**. **Payments** are subject to the **Maximum Overhead Expense Benefit** and shall not exceed 6 **Monthly Overhead Expense Benefits** (each day is paid at 1/30th the **Partial Disability Benefit**). **Benefits** are not paid for both **Sickness** and **Injury** for the same period of **Partial Disability**.

PRESUMPTIVE DISABILITY BENEFIT. **We** presume **You** are **Totally Disabled** if **You** suffer total loss of speech, hearing, sight, or suffer amputation of hands and/or feet as described in the **Policy**. **We** pay the **Monthly Overhead Expense Benefit** up to the **Maximum Overhead Expense Benefit** whether or not **You** are able to work. **We** do not apply the **Elimination Period** to this **Benefit**.

SURVIVOR BENEFIT. **We** pay **Your Beneficiary** a lump sum of 2 times the **Monthly Overhead Expense Benefit** if **You** die while **Totally Disabled** and have received **Monthly Overhead Expense Benefits** for at least 12 months.

REHABILITATION BENEFIT. You, We, and society all benefit by helping You return to work. We will consider helping You pay the costs of a *Rehabilitation Program* if You are **Totally Disabled**. We determine how much is paid up to a maximum of 6 **Monthly Overhead Expense Benefits**. Not everyone can go back to work, but if Your **Physician** advises that You would likely return to work with a **Rehabilitation Program**, We will require it. We will not pay **Monthly Overhead Expense Benefits** unless You take part. If We require You to take part in a **Rehabilitation Program**, We may pay more than the 6 **Monthly Overhead Expense Benefits** limit.

MILITARY SERVICE. The **Policy** is suspended if You enter **Active Military Service**. **Active Military Service** is Military Service of any country or international authority. **Active Military Service** does not include active duty for training that lasts less than 60 days. You can put the **Policy** back in force when You are released from **Active Military Service**. To do this, We will need Your written request and payment of **Premium** within 90 days of Your release. The **Premium** is the same as if the **Policy** had stayed in force.

You do not need to prove You are healthy to have the **Policy** put back in force. The restored **Policy** will only cover loss from

- **Injury** after the restoration date; and
- **Sickness** that **Originates** more than 10 days after the restoration date.

CONVERSION. You can convert an in force **Policy** to an individual **Disability Income Insurance Policy** if

- the **Policy** has been in force for at least 2 years;
- You are not yet age 60;
- You request conversion in writing; and
- You are not **Totally** or **Partially Disabled**.

The new **Policy** must be one We then currently issue. The **Monthly Benefit** under the new **Policy** can be as much as the **Maximum Monthly Overhead Expense Benefit** under the original **Policy**. However, the coverage under the new **Policy** along with all individual disability income coverage You have cannot exceed **Our Limits**. "Limits" means the maximum coverage We offer to new applicants of Your risk class at the time of Your request.

The **Premium** for the new **Policy** will be based on **Our** rates in effect at the time of Your request for Your age at the time of application. Your rate class will be the same as for the original **Policy**. You should also know the following:

- a. **STATEMENTS MADE IN YOUR APPLICATION.** For purposes of this clause, the **Issue Date** for the new **Policy** is the same as for the original **Policy**.
- b. The new **Policy** will only cover **Disabilities** which begin while it is in force. It will only exclude conditions excluded by the original **Policy**.
- c. You do not need to prove You are healthy to convert the original **Policy**.

PREMIUMS

PREMIUM PAYMENTS. The **First Premium** is due on the **Issue Date**. Premiums will include **Rider Premiums**. Premiums due after the first Premium are **Renewal Premiums**. **Renewal Premiums** are paid at the **Premium Payment Interval**. You can change this. **Renewal Premiums** are due when the last payment runs out. The date the next **Renewal Premium** is due is the **Due Date**. **Renewal Premiums** are paid in advance of the **Due Date**. All **Premiums** are paid to the **Administrative Office**. Except as stated under **GRACE PERIOD**, Your Policy will end if a **Renewal Premium** is not paid by the next **Due Date**.

GRACE PERIOD. You have a **Grace Period** to make **Renewal Premium** payments which starts on the **Due Date** and ends 31 days later. During the **Grace Period Your Policy** stays in force. If You do not pay the **Renewal Premium** by the end of the **Grace Period Your Policy** will end (lapse).

REINSTATEMENT. If Your Policy lapses for nonpayment of a **Renewal Premium**, You can **Reinstate** it if We agree You are insurable. You must apply for **Reinstatement** within 12 months of the lapse (end of **Grace Period**) and pay a **Renewal Premium**. The **Effective Date of Reinstatement** is the date We agree You are insurable. The **Renewal Premium** is applied from the **Effective Date of the Reinstatement**. If We have not already acted, Your Policy will be **Reinstated** 45 days after You apply for **Reinstatement** and pay the **Renewal Premium**. The **Reinstated Policy** will only cover **Total Disability** due to **Injury** received after the **Effective Date of Reinstatement** or **Sickness** which **Originates** more than 10 days after the **Effective Date of Reinstatement**. The **Preexisting Condition** limits apply to the **Application** for **Reinstatement**, and We can add new **Policy Amendment Riders** to the **Reinstated Policy**.

PREMIUM FOR THE POLICY. The **Premium** shown below is payment for the **Policy Benefits** based on the **Monthly Overhead Expense Benefit, Elimination Period** and **Maximum Overhead Expense Benefit**.

PREMIUM PAYMENT MODES shows the various **Premium Payment Periods**.

TOTAL DISABILITY BENEFITS: Monthly Overhead Expense Benefit:
Maximum Benefit Overhead Expense :
Elimination Period:

PARTIAL DISABILITY BENEFITS: Monthly Overhead Expense Benefit.

PREMIUM PAYMENT MODES: Annual
Semi-Annual
Quarterly
Monthly

See Outline printed with the policy for specific information.

LIMITATIONS AND EXCLUSIONS

MENTAL/NERVOUS DISORDERS. We will only pay **Monthly Overhead Expense Benefits** for a total of 24 months during **Your** lifetime for **Total Disability** due to **Mental/Nervous Disorders** (*defined in the Policy*) or which are caused or contributed to by abuse of drugs or alcohol. However, **We** will pay normal **Policy Benefits** as long as **You** are confined in a hospital under a **Physician's** care for any of these conditions.

FOREIGN TRAVEL. We will only pay 3 **Monthly Overhead Expense Benefits** for any **Total Disability** sustained or continued outside the United States, Canada, or Mexico.

PREEXISTING CONDITIONS. If **Your Total Disability** is 2 years years from the **Issue Date** and is due to a **Preexisting Condition**, **Benefits** will not be paid unless the condition was disclosed and not misrepresented on **Your Application**, and is not excluded by a **Policy Amendment Rider**.

EXCLUSIONS. We will not pay **Monthly Overhead Expense Benefits** for loss caused by

- war or act of war whether or not declared;
- intentional self-inflicted **Injury** or **Sickness**;
- committing or attempting to commit a felony;
- **Your** engaging in an illegal occupation; or
- normal pregnancy (except **We** will cover **Total Disability** caused by pregnancy or childbirth on the 91st day of **Total Disability**).

We cover involuntary **Complications of Pregnancy** as **Sickness**, which includes eclampsia, toxemia, hyperemesis gravidarum, anemia of pregnancy, placenta previa, ectopic pregnancy, puerperal infection, Caesarean Section delivery and miscarriage.

We will not pay **Monthly Overhead Expense Benefits** for any **Total Disability** which starts while **You** are incarcerated in a penal institution or government detention facility.

RENEWABILITY

This **Policy** is **Guaranteed Renewable** to age 65. That means as long as **You** pay **Premiums**, **We** cannot cancel or change **Your Policy** until the **Policy Anniversary** after **Your** 65th birthday. **We** can, however, change the **Premium** rates. If **We** do, **We** can only do it to all **Policies** in **Your** class. **We** will give **You** 31 days notice if **We** change **Premium** rates. If **You** are over age 65 and **Employed on a Full-Time Basis**, **You** can continue to renew **Your Policy** up to age 70. **You** must be **Employed on a Full-Time Basis** and be responsible for paying **Business Overhead Expenses** on each renewal date. There will be a limited benefit period.

RIGHT TO CANCEL

You may cancel the **Policy** within 30 days of receiving it. Return the **Policy** to **Assurity's Administrative Office** or to **Your Assurity** sales agent. As soon as **You** deliver or mail the **Policy** to **Us** it is treated like it was never issued. **We** will refund **Your Premium** payment when **We** get the **Policy** back. After the first 30 days, **You** may cancel this **Policy** at any time by telling **Us** so in writing. Cancellation will be effective on the date **We** receive **Your** written notice or the date **You** specify in **Your** notice, whichever is later. Upon cancellation **We** will promptly return any unearned **Premium** paid. Cancellation will not prejudice any claim originating before the effective date of cancellation.

**THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED.
CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**