



California Elder Notice to All Purchasers of Life Insurance or Annuities Age 65 or Over

You should be aware that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this life or annuity product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale or sold.

I have read the above notice and have received a copy.

Signature and Printed Name of Prospective Purchaser

Date (MM/DD/YYYY)

Signature and Printed Name of Prospective Purchaser's Spouse or Joint Owner

Date (MM/DD/YYYY)

Signature and Printed Name of Prospective Purchaser's Representative

Date (MM/DD/YYYY)





IMPORTANT NOTICE:

This notice is being provided to you in accordance with California law.

1. During this visit or a follow-up visit, you will be given a sales presentation on the following (*indicate all that apply*):

Life insurance, including annuities

Other insurance products (*specify*): _____

2. You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

3. You have the right to end the meeting at any time.

4. You have the right to contact the Department of Insurance for information, or to file a complaint.

You may contact the California Department of Insurance Consumer Hotline from 8:00 a.m. to 6:00 p.m., Monday through Friday, at 1-800-927-HELP (4357).

5. The following individuals will be coming to your home: (*List all attendees and insurance license information, if applicable.*)





NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

RECOVERY

An annuity purchased on or after Sept. 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after Sept. 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than the amount of an individual's resource allowance in countable resources (*\$2,000 for 2007*). The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance (*\$35 for 2007*) plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

- **Community Spouse Resource Allowance:** If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than the amount of community countable assets (*\$101,640 in 2007*).
- **Minimum Monthly Maintenance Needs Allowance:** If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or \$2,541 (*for 2007*), whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than the amount of community spouse resource allowance (*\$101,640 for 2007*). The order also may allow the at-home spouse to retain more than \$2,541 (*for 2007*) in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

- **One principal residence:** One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home some day. The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it. Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- **Real property used in a business or trade:** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.



PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

- **IRA, KEOGH, or other work-related pension plans:** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity or otherwise change the form of the assets in order for them to be unavailable.
- **Personal property used in a trade or business.**
- **One motor vehicle.**
- **Irrevocable burial trusts or irrevocable prepaid burial contracts.**

THERE MAY BE OTHER ASSETS THAT ARE EXEMPT. This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

Purchaser's Signature and Printed Name

Date (MM/DD/YYYY)

Spouse's Signature and Printed Name

Date (MM/DD/YYYY)

Legal Representative's Signature and Printed Name

Date (MM/DD/YYYY)





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

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

California Application for Universal Life Insurance

This application includes all forms needed to apply for Universal Life Insurance.
This application does not include the Disability Income or Critical Illness section(s).

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

You may write a Disability Income or Critical Illness application* in combination with this Life application. In addition to this application, simply complete the appropriate Disability Income or Critical Illness section(s) obtained from AssureLINK or from a Disability Income 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, 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 _____ / _____ <i>Years Months</i>											
Primary Employer			Employer's Address		<i>Street Address</i>		<i>City</i>		<i>State ZIP+4</i>		
Full-time Employment					<i>Occupation Duties</i>		Part-time Employment				
Gross monthly income \$					If self-employed, net monthly income \$						



TRUST INFORMATION/ADDITIONAL BENEFICIARY

Please complete the following sections if Ownership and/or Beneficiary is a trust (or if additional room is needed to list beneficiaries of Policy):

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

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

2. BENEFICIARIES (Do not complete if applying for Reversionary Annuity)

Primary Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Social Security No.	Date of Birth (<i>MM/DD/YYYY</i>)	Share %
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
Contingent Beneficiary Name (<i>First, Middle, Last</i>)	Relationship	Social Security No.	Date of Birth (<i>MM/DD/YYYY</i>)	Share %
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
<input type="checkbox"/> Testamentary Trust (<i>Will</i>)	N/A	N/A	N/A	
<input type="checkbox"/> Living Trust (<i>Please complete section below.</i>)	N/A	N/A	N/A	

Name of Living Trust _____

Date of Trust (*MM/DD/YYYY*) / / Tax ID No. of Trust _____

Name of Trustee(s) _____

Address of Trustee(s) _____

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. NOTICE: California law prohibits a human immunodeficiency virus (HIV) test from being required or used by health insurance companies as a condition of obtaining health insurance.

1.	To the best of your knowledge, during the past 10 years , has any Proposed Insured 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.	a. Has any Proposed Insured ever tested positive for HIV antibodies as part of a test for obtaining insurance?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Has any Proposed Insured been diagnosed as having, been treated or recommended for treatment by a medical professional for acquired immune deficiency syndrome (<i>AIDS</i>), AIDS-related complex (<i>ARC</i>) or any other disorder of the immune system (<i>excluding HIV status</i>)?.....	<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 (MM/DD/YYYY) / /	

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
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			

Additional Information:

Home Office Use Only



UNIVERSAL LIFE PRODUCT SECTION

Plan of Insurance (Specify UL plan name): _____

Base Amount \$ _____ Special Policy Date (If desired) _____

Planned periodic premium \$ _____ Amount of Insurance is Face Amount unless shown differently here: Face + Accumulated Value

ADDITIONAL BENEFITS

Check benefit(s) desired and indicate amount requested.

- Disability Waiver
- Face Amount Increase Rider \$ _____
- ADB (Accidental Death Benefit) \$ _____
- 10-year Term Rider \$ _____
- 20-year Term Rider \$ _____
- 10-year Additional Insured/Spouse Rider \$ _____
- 20-year Additional Insured/Spouse Rider \$ _____
- Children's Term Rider \$ _____
- Other (Please specify) _____ \$ _____
- Other (Please specify) _____ \$ _____

Information	Additional Ins./Child Rider No. 1	Additional Ins./Child Rider No. 2	Additional Ins./Child Rider No. 3
Name (First, Middle, Last)			
Face Amount/Units (Child Rider)	\$ /	\$ /	\$ /
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /
Age			
Social Security No.	- -	- -	- -
Birth State/Country			
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Relationship to Insured			
Employer			
Occupation			
Gross monthly income	\$	\$	\$
If self-employed, net mo. income	\$	\$	\$



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:

- 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.
- 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.
- 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.

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.





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.

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 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





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

**Life Insurance or Annuity
 REPLACEMENT NOTICE**

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

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

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

INFORMATION ON POLICIES WHICH MAY BE REPLACED

COMPANY NAME	POLICY NO.	NAME OF INSURED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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





REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature and Printed Name

Date (MM/DD/YYYY)

Agent's Signature and Printed Name

Date (MM/DD/YYYY)

INFORMATION ON POLICIES WHICH MAY BE REPLACED

COMPANY NAME	POLICY NO.	NAME OF INSURED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To be completed if replacing another company's policy

Signed form to be returned to home office

Applicant to receive a copy of this form at the time the application is taken



ILLUSTRATION DISCLOSURE STATEMENT

Proposed Insured's Knowledge and Agent's Certification of

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

PROPOSED INSURED ACKNOWLEDGEMENT

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

Proposed Insured's Signature

Date

AGENT CERTIFICATION

I certify that:

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

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

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

Agent Signature

Date



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

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

1. Source of Funds

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

2. Intended purpose of applied for coverage

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

3. Applicant's background

- Length of time known *(in years)* _____
- Nature of relationship _____
- Business relationship with applicant? Yes No If so, describe _____
- How known _____
- Applicant's occupation _____

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

5. Source of information

Name _____

- Applicant
- Owner
- Payor
- Other *(specify)* _____

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

Producer Signature

Producer No.

Producer Name

Date (MM/DD/YYYY)

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





A. INSTRUCTIONS

1. Owner's signature and date of completion are required on this form.
2. For transfers or 1035 exchanges from annuities or life products, a replacement form must be completed if required by state.
3. Use a separate form for each company. Please print in black ink.

B. COMPANY INFORMATION

_____		()	
Current Trustee/Custodian/Insurance Company		Telephone No.	
_____	_____	_____	_____
Company Address	City	State	ZIP+4
_____		_____	
Contract/Policy/Account No.		Investment Vehicle (CD, Mutual Fund, Life Insurance, Annuity)	
_____	_____	_____	_____
Insured/Annuitant's Full Name	Social Sec. or Tax I.D. No.	Joint Insured/Annuitant's Full Name	Social Sec. or Tax I.D. No.
_____	_____	_____	_____
Policyowner/Account Owner's Full Name (if different from Insured or Annuitant)	Social Sec. or Tax I.D. No.	Joint Owner's Full Name (if applicable)	Social Sec. or Tax I.D. No.

C. POLICY INFORMATION

The contract is: ENCLOSED NOT ENCLOSED (*partial exchange only*)
 LOST/DESTROYED—I certify that the policy is lost or destroyed. I also certify that the policy has not been assigned or pledged as collateral.

D. COMPANY DESIGNATION

On the basis of the authorization and/or assignment below, please liquidate the above assets and send the proceeds to:
 Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533 _____
 Assurity Life Insurance Policy/Contract No.

E. TYPE OF TRANSFER

Please select one of the following options:

Please note: A transfer/surrender of a life insurance policy to an annuity, or an annuity to another annuity, qualifies as a 1035 exchange. A transfer/surrender of an annuity to a life insurance policy does NOT qualify as a 1035 exchange—any gain on your existing annuity will be subject to income tax.

1. **1035 EXCHANGE** from a nonqualified annuity or life insurance policy(ies) (*including IRS Section 457 Deferred Compensation*).
- I hereby make a complete and absolute assignment (*endorsement for contracts that are not assignable*) and transfer all rights, title and interest of every nature and character in and to the above policy to the insurance company indicated above in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. I represent that the above policy is not subject to any pledge, assignment, levy or legal proceeding. Upon receipt, the insurance company is directed to surrender all or part of the policy and apply the value to an annuity or life insurance policy for which I have submitted an application. I understand that by executing this assignment, I irrevocably waive all rights, claims and demands under the above policy. I am aware of all penalties which may apply.
- I acknowledge that the insurer is furnishing this form and participating in this transaction as an accommodation to me, and the indicated insurer assumes no responsibility or liability for my tax treatment under Section 1035 of the Internal Revenue Code or otherwise.

NOTICE REGARDING PARTIAL 1035 EXCHANGES AND EXCHANGES TO EXISTING CONTRACTS: Partial exchanges with subsequent withdrawals or annuitizations may be subject to IRS challenge if entered into for the purpose of avoiding premature withdrawal or other penalties. In addition, the Internal Revenue Service has not issued guidelines regarding the apportionment of basis between contracts involved in partial exchanges. Until such guidance is issued, Assurity will utilize a pro-rata formula for such apportionment. While Assurity believes this will be consistent with any IRS guidelines ultimately issued, these guidelines could mandate a different allocation method. Exchanges into existing contracts should be approached cautiously, and only after consultation with a tax advisor, since the IRS has not yet issued definitive guidance regarding the permissibility of such exchanges.

In accordance with these directions, please remit the value indicated below:

- COMPLETE: Surrender/Liquidate all assets in my account totaling \$ _____
- PARTIAL: Surrender/Liquidate assets totaling \$ _____

Transfer the proceeds:

- IMMEDIATELY: I am aware of all penalties which may apply.
- UPON MATURITY Maturity date ____ / ____ / ____ (MM/DD/YYYY)



E. TYPE OF TRANSFER (Continued)

2. **TRANSFER NON-QUALIFIED ACCOUNT(S)**

In accordance with these directions, please remit the value indicated below:

COMPLETE: Surrender/Liquidate all assets in my account totaling \$ _____

PARTIAL: Surrender/Liquidate assets totaling \$ _____

Transfer the proceeds:

IMMEDIATELY: I am aware of all penalties which may apply.

UPON MATURITY Maturity date ____ / ____ / ____ (MM/DD/YYYY)

3. **TRANSFER QUALIFIED RETIREMENT ACCOUNT(S) (CURRENT PLAN TYPE)**

ROTH IRA Simple IRA Traditional IRA SEP IRA

KEOGH 401(k) Qualified Retirement Plan

As owner of the plan indicated above, I hereby request a liquidation of this account to effect a transfer of assets to the Company designated in Section D. I have submitted an application to that Company to establish an account for this transfer.

In accordance with these directions, please remit the value indicated below:

COMPLETE: Surrender/Liquidate all assets in my account totaling \$ _____

PARTIAL: Surrender/Liquidate assets totaling \$ _____

Transfer the proceeds:

IMMEDIATELY: I am aware of all penalties which may apply.

UPON MATURITY Maturity date ____ / ____ / ____ (MM/DD/YYYY)

Is this a transfer to an existing account? YES NO If YES, provide policy no. _____

4. **TRANSFER OF ASSETS TO AN ANNUITY CONTRACT (i.e. nonqualified mutual funds or bank account(s), does not include 1035 exchanges)**

Annuity CD Maturity date ____ / ____ / ____ (MM/DD/YYYY)

Bank or Credit Union Account Mutual Fund Other _____

As owner of the plan indicated above, I hereby request a liquidation of this account to effect a transfer of assets to the Company designated in Section D. I have submitted an application to that Company to establish an account for this transfer.

In accordance with these directions, please remit the value indicated below:

COMPLETE: Surrender/Liquidate all assets in my account totaling \$ _____

PARTIAL: Surrender/Liquidate assets totaling \$ _____

Transfer the proceeds:

IMMEDIATELY: I am aware of all penalties which may apply.

UPON MATURITY Maturity date ____ / ____ / ____ (MM/DD/YYYY)

Is this a transfer to an existing account? YES NO If YES, provide policy no. _____

F. SIGNATURES

Under penalty of perjury, I certify that the foregoing information is true, correct and complete.

Date (MM/DD/YYYY)

Signature of Contract Owner

Printed Name

Date (MM/DD/YYYY)

Signature of Joint Owner (if applicable)

Printed Name

SIGNATURE GUARANTEE

ASSURITY LIFE INSURANCE COMPANY

By _____

Title _____

