



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

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

## Washington 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](mailto:underwriting@assurity.com).**



**1. PROPOSED INSURED**

|   |   |                |   |     |
|---|---|----------------|---|-----|
| Legal Name<br><i>First Middle Last</i>  |   |                | Date of Birth<br><i>(MM/DD/YYYY)</i><br>/ / |     |
| Social Security No.   | <input type="checkbox"/> Male <input type="checkbox"/> Female | E-mail         |   | Age |
| Home Address<br><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<br>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<br><i>Street Address City State ZIP+4</i>  |                |   |     |
| Full-time Employment<br><i>Occupation Duties</i>  | Part-time Employment<br><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<br><i>First Middle Last</i>                 |  |                     | Date of Birth<br><i>(MM/DD/YYYY)</i><br>/ / |  |
| Social Security No.                                    | Relationship to Insured                    | Birth State/Country |   |  |
| Home Address<br><i>Street Address City State ZIP+4</i> | E-mail Address                             |                     |   |  |
| Contingent Owner's Name<br><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<br><i>First Middle Last</i>            | Billing Address<br><i>Street Address City State ZIP+4</i> |
| Secondary Payor Info.<br><i>First Middle Last</i> | Billing Address<br><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)<br>/ / |              |      |
| 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 _____ / _____<br><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 |     |                     |              |      |
|  |  |  |   |                       |                       |   |                      |     |                     |              |      |
| 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>MI</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>MI</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, MI, Last</i> )                             | Relationship | Soc. Sec. No. | Date of Birth ( <i>MM/DD/YYYY</i> ) | Share % |
|---|--------------|---------------|-------------------------------------|---------|
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
|   |              | - -           | / /                                 |         |
| Contingent Beneficiary Name ( <i>First, MI, Last</i> )                          | Relationship | Soc. Sec. 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)<br>Group (G)                           | Benefits (monthly benefit<br>and benefit period for DI<br>or face amount for Life) | Issue Date<br>(MM/DD/YYYY) | DI Coverage Only  |   |
|--------------|------------|---|--|----------------------------|---|---|
|              |            |   |  |                            | Coordinates w/<br>SOC. Sec.?                                | Employer<br>Paid?   |
| _____        | _____      | <input type="checkbox"/> I <input type="checkbox"/> G | _____  | /    /                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| _____        | _____      | <input type="checkbox"/> I <input type="checkbox"/> G | _____  | /    /                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| _____        | _____      | <input type="checkbox"/> I <input type="checkbox"/> G | _____  | /    /                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><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 <b>ever</b> 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 <b>5 years</b> , 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 <b>ever</b> 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 <b>ever</b> 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<br>(First, Middle, Last) | Onset Date<br>(MM/DD/YYYY) | Duration<br>(Days, Mos, Yrs) | Health Condition<br>and Details | Medical Care Provider's<br>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, MI, 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.

**It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fine and denial of insurance benefits.**

**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
  - Abbreviated paramedical examination (*Tele-app only*.)
  - Paramedical examination with Home Office (*H.O.*) specimen. (*Preferred classifications require blood profile, not dried blood spot.*)
  - Medical exam by physician with H.O. specimen  Chest X-ray  Blood Profile  Electrocardiogram  Treadmill
 Name and address of examiner \_\_\_\_\_  
 Date above items to be completed (MM/DD/YYYY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- 4. 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.
- 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](http://www.mib.com).

## Insurance Information Practices

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

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

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

## Fair Credit Reporting Act

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

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

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

## Telephone Interview Information

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



## Conditional Receipt

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

The following Conditional Receipt is issued by Assurity Life Insurance Company when the full initial premium is collected from the Proposed Insured/Owner at the time the application is completed. The full initial premium may be collected when the amount of in-force and applied for individual life coverage, 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: \_\_\_\_\_

**WASHINGTON PRE-COUNSELING FACILITIES**  
**WASHINGTON STATE OFFICE OF PREVENTION AND EDUCATION SERVICES**  
**HIV ANTIBODY TESTING/COUNSELING SERVICES, 206-586-0426, SCAN 321-0426**

Adams County Health Department  
103 West Main  
Ritzville, WA 99169  
509-659-0090 Ext. 206

Asotin County Health District  
431 Elm Street  
Clarkston, WA 99403  
509-758-4565

Benton-Franklin Health District  
506 McKenzie  
Richland, WA 99352  
509-943-2614 (Richland)  
509-546-5448 (Pasco)  
509-586-0207 (Kennewick)

Bremerton-Kitsap County Health Department  
109 Austin Drive  
Bremerton, WA 98312  
206-478-5235; 1-800-874-2437

Chelan-Douglas County Health District  
316 Washington Street  
Wenatchee, WA 98801  
509-664-5306

Clallam County Health Department  
223 E. Fourth Street  
Port Angeles, WA 98362  
206-452-7831

Columbia County Health District  
221 E. Washington St., Suite 101 PH  
Dayton, WA 99328  
509-382-2181

Cowlitz-Wahkiakum Health District  
516 Hudson  
Longview, WA 98632  
206-425-7400

Garfield County Health District  
10<sup>th</sup> & Columbia (P.O. Box 130)  
Pomeroy, WA 99347  
509-843-3412

Grant County Health District  
County Courthouse  
First & C St., NW (P.O. Box 37)  
Ephrata, WA 98823  
509-754-2011, Ext. 372

Grays Harbor County Health Department  
2109 Summer Ave.  
Aberdeen, WA 98520  
206-532-8631

Island County Health Department  
410 N. Main (P.O. Box 5000)  
Coupeville, WA 98239  
206-679-7351

Jefferson County Health Department  
Castle Hill Center  
615 Sheridan  
Port Townsend, WA 98368-2439  
206-385-9400

Kittitas County Health Department  
507 Nanum  
Ellensburg, WA 98926  
509-962-7515

Lewis County Health District  
Health Services Building  
360 N.W. North St. (P.O. Box 706)  
Chahalis, WA 98532  
206-748-3721, Ext. 223

Lincoln County Health Department  
507 7<sup>th</sup> St. (P.O. Box 215)  
Davenport, WA 99122  
509-725-1001

Mason County Health Department  
303 North 4<sup>th</sup>  
Shelton, WA 98584  
206-427-9670, Ext. 400

Northeast Tri-County Health District  
240 East Dominion (P.O. Box 270)  
Colville, WA 99114  
509-684-5048

Okanogan County Health District  
237 N Fourth St. (P.O. Box 231)  
Administration Building  
Okanogan, WA 98840  
509-422-3867

Pacific County Health Department  
1216 W. Robert Bush Drive  
South Bend, WA 98586  
206-875-9343



San Juan County Health Department  
145 Rhone St. (P.O. Box 607)  
Friday Harbor, WA 98250-0607  
206-378-4474

Seattle-King County Health Department  
AIDS Prevention Unit  
(gay/bisexual men preferred)  
2124 Fourth Ave., 4<sup>th</sup> Floor  
Seattle, WA 98104  
206-296-4999, TTY 206-296-4843  
1-800-678-1595

Harborview Hospital  
Sexually Transmitted Disease Clinic  
325 9<sup>th</sup> Ave., 3<sup>rd</sup> Floor, South Wing  
Seattle, WA 98104  
206-223-3590  
Harborview Women's Clinic 223-3367

Seattle Gay Clinic  
500 19<sup>th</sup> Ave. East  
Seattle, WA 98102  
206-431-4540

Skagit County Health Department  
Courthouse Administration Bldg.  
700 South Second St., Room 301  
Mount Vernon, WA 98273  
206-336-9380

Snohomish Health District  
3020 Rucker, Suite 206  
Everett, WA 98201  
206-339-5251; 1-800-344-2437

SW Washington Health District  
Vancouver-Clark County Health  
2000 Fort Vancouver Way  
Vancouver, WA 98663  
206-696-8425

Spokane County Health District  
West 1101 College Ave.  
Spokane, WA 99201  
509-324-1600; 1-800-456-3236

Tacoma-Pierce County Health  
3629 South D St.  
FC 3365  
Tacoma, WA 98408  
206-591-6060

Thurston County Health Department  
529 Southwest Fourth  
(MS:FQ-11)  
Olympia, WA 98501  
206-786-5581

Walla Walla County-City  
Health Department  
310 West Poplar  
(P.O. Box 1753)  
Walla Walla, WA 99362  
509-527-3290

Whatcom County Health Department  
1500 N. State Street  
Bellingham, WA 98225  
206-676-4593

**LOW RISK TESTING SITES (SEA-KING CO.)**

North Seattle Public Health Center  
10501 Meridan Ave. North  
Seattle, WA  
206-296-4990

Southeast Public Health Center  
3001 NE 4<sup>th</sup> Street  
Renton, WA  
206-296-4900

Southwest Public Health Center  
10821 8<sup>th</sup> Ave. SW  
Seattle, WA 206-296-4620

East Public Health Center  
2424-156<sup>th</sup> Ave. NE  
Bellvue, WA  
206-296-4920

Southeast Public Health Center  
20 Auburn Ave.  
Auburn, WA  
206-833-8500

Central Clinic  
Public Safety Building  
610-3<sup>rd</sup> Ave., 14<sup>th</sup> Floor  
Seattle, WA  
206-296-4772

Whitman County Health Department  
Public Service Building  
North 310 Main Street  
Colfax, WA 99111  
509-397-6280

Yakima County Health District  
104 North First Street  
Yakima, WA 98901  
509-575-7959; 1-800-535-2271





## **HIV (AIDS VIRUS) ANTIBODY TEST INFORMED CONSENT FORM**

### **INTRODUCTION**

Please read this form carefully before making your decision to be tested or not. Human Immunodeficiency Virus (*HIV*) is the cause of acquired immunodeficiency syndrome (*AIDS*). All persons infected with HIV can spread it to others through unprotected sexual contact, or sharing needles and equipment. Infected mothers can also give HIV to their unborn children. HIV is also found in breast milk of infected mothers.

In almost all situations, testing for HIV infection is voluntary. The HIV antibody test can be performed on a sample of blood, urine, or from tissue secretions inside the mouth.

### **WHAT THE TEST MEANS**

This test detects antibodies to the HIV virus. Antibodies are produced in the body when the virus enters the body.

A **Negative** test result means:

- HIV antibodies were not found at this time or;
- You do not have HIV or;
- You may have tested too soon after infection. It may take between three to six months from the time you were infected with the virus for the test to become positive. Based on your exposure, a follow-up test may be highly recommended.

A **Positive** test result means:

- You are infected with HIV, the virus that causes AIDS.
- You may pass on HIV to others.
- You should seek additional medical information, treatment and counseling.

An **Indeterminate** test result means:

- You may have another condition that is causing your immune system to falsely react to the HIV antibody test.
- You may have been recently infected.
- Referral to a specialist for repeat testing or special confirmatory testing should be pursued to determine whether HIV infection is present.

### **BENEFITS OF BEING TESTED**

There are several benefits to being tested. Most infected persons benefit from taking medication that may delay the onset of AIDS and other serious infections. It is important that all infected persons get a complete medical checkup so that their health care providers can provide the most appropriate recommendations about treatment, care and support services. In addition, knowing test results can help people in making choices about contraception and pregnancy. Many persons find that knowing their test results encourages them to practice safer sex practices with their partners, not share drug injection equipment or seek drug treatment. If you are pregnant, treatment for HIV can help prevent giving the disease to your child. Some people want to know their HIV status before beginning a new relationship, or becoming pregnant. Others will be reassured by learning that they are not infected.

### **RISK AND DISADVANTAGES OF BEING TESTED**

Many persons with positive test results will experience stress, anxiety or depression. Some persons with negative test results may continue, or increase unsafe behaviors. Some persons are concerned that their test results will get into the wrong hands, and that they may be discriminated against. (*See Privacy and Confidentiality below*). Before being tested you should consider your social supports (*such as family and friends*).

### **PRIVACY AND CONFIDENTIALITY**

Some people are concerned that their test results will get into the wrong hands. Penalties for violations of the confidentiality laws are severe. We keep a record of the health services we provide to you. We will not disclose your record to any one else unless you ask us to do so, or unless the law authorizes us to do so.

Washington State law says that with **Confidential HIV testing** the name or identity of the individual tested for HIV will be recorded and linked to the HIV test result, and that the name of the individual testing positive for HIV will be reported to the state or local health officer in a private manner. The local health department changes names into codes, and after 90 days, the name must be destroyed by law. No lists with names are maintained and names cannot be recreated from codes.

Washington State law states that **Anonymous HIV testing** means that the name or identity of the individual being tested for HIV will not be recorded or linked to the HIV test result. If you test anonymously, your record will be identified by your personal code, not your name. To learn your test result you must confirm your identity with your personal code. This is different than the code, which is used to protect the confidentiality of reported cases. Once an individual who tests positive receives HIV health care or treatment services, reporting of the individual to the state or public health officer is required.





# HIV ANTIBODY TEST PRE-TEST INFORMATION SHEET

## HIV ANTIBODY TEST AND AIDS

The following information is designed to help you decide if you should take a blood test for antibody to the human immunodeficiency virus (*HIV*). HIV is the virus that is the primary cause of the acquired immunodeficiency syndrome (*AIDS*). AIDS is a serious disease in which the body's immune system has been injured and no longer works properly, resulting in different types of infections and cancer.

This is a test for the antibody to the virus, but it is not a test for AIDS. A positive antibody test means that your body has been infected with HIV and that your immune system has made a substance (*antibody*) directed against the virus. Although this is not a test for the virus itself, there is a high likelihood that a positive antibody test also means that the virus is in your system, and that you may be "carrying" the virus which could be transmitted to other people.

It is not known with certainty if a person with a positive antibody test will develop AIDS; it is currently estimated that up to 20-25 percent of people with HIV infection will develop AIDS within six years, and an additional 25-30 percent will develop other less serious medical conditions such as swollen lymph nodes, fever, fatigue, night sweats or weight loss. The long-term prognosis of most persons with HIV infection is unknown.

## "HIGH-RISK" AND "LOW-RISK" GROUPS FOR HIV INFECTION AND AIDS

Populations which have been identified as at high-risk for HIV infection and possible development of AIDS include homosexual or bisexual men, injection drug users, people who took certain treatments for hemophilia before these products were made safe, sexual contacts of people in these groups, sexual contacts of HIV-positive individuals, and people from countries where the virus is more frequently present (*such as Central Africa*). Populations at low-risk include anyone not in one of the high-risk groups.

A positive HIV antibody test in a person from a high-risk group indicates infection with the virus. A negative test in a person from a high-risk group usually indicates absence of infection. However, a small percentage of high-risk persons will have a false-negative test, meaning that the virus is present but the antibody is not. This could indicate that the exposure was so recent that the virus is still incubating and the antibodies have not developed. The incubation period for the virus is believed to be six to 12 weeks. The longest time between conversion from negative to positive reported to the Centers for Disease Control is 14 weeks. Based on this data, if a repeat test is negative three months after exposure, then HIV infection is probably not present.

A positive test in a person from a low-risk group usually indicates infection with the virus. However, some low-risk persons may have a false-positive test, meaning actual HIV antibody is absent, but the test is positive because of another substance in the blood. In these cases, further medical evaluation or other tests will help decide if the test is true or false positive. A negative test in a person from a low-risk group means HIV infection is not present.

## POTENTIAL ADVANTAGES OF THE HIV ANTIBODY TEST

If your test is positive, you will gain knowledge of an important medical condition you need to know about and understand further, and be able to inform your sexual partner(s), physician and dentist. By knowing of your HIV infection, you can take measures to prevent transmission to others, to possibly prevent the development of AIDS, and to become a candidate for treatment against the virus if such therapy becomes available.

If your test is negative three months after the last possible exposure, you will learn that you do not have the HIV infection, that you can take measures to prevent becoming infected, and that you are not likely to develop AIDS. You might then benefit from a vaccine to prevent HIV infection if it becomes available.

## CONFIDENTIALITY

Records of this test, if submitted under your name, will be maintained in files at the local health clinic where the test was conducted. Only public health workers have access to these files. The information about HIV testing in these records is considered confidential; it will not be released to another person, physician, health care agency, government institution, insurance company or employer without your written permission. This information may be compiled for public health statistics or for research purposes, but in these situations, personal identifiers are not used.

THE RESULTS OF THIS TEST WILL ONLY BE REVEALED TO YOU IN PERSON UPON PRESENTATION OF THIS FORM, OVER THE PHONE OR THROUGH THE MAIL. THIS WILL BE DONE TO PROTECT CONFIDENTIALITY AND TO FURTHER DISCUSS THE RESULTS AND INTERPRETATION OF YOUR HIV ANTIBODY TEST.

Client provided a copy and offered opportunity to ask questions?  Yes  No

\_\_\_\_\_  
*Counselor*

\_\_\_\_\_  
*Date (MM/DD/YYYY)*

\_\_\_\_\_  
*Test Number*

\_\_\_\_\_  
*Race/Ethnicity*

\_\_\_\_\_  
*Birth Date (MM/DD/YYYY)*

Male  Female



## **IF YOUR TEST IS NEGATIVE . . .**

### **ANSWERS TO QUESTIONS ABOUT THE HIV ANTIBODY BLOOD TEST**

AIDS is caused by HIV, a virus which attacks the body's immune system. People who have been infected by the virus produce "antibodies" to the infection; these antibodies are what the blood test measures. Your negative test probably means that you have not been infected with the virus BUT:

- A NEGATIVE TEST DOES NOT MEAN THAT YOU ARE IMMUNE. If you engage in high-risk activities, you can still become infected with the virus.
- You may have been tested so soon after you were exposed to the virus that antibodies have not appeared in your blood yet. You may be infected, and if you are, you can infect others.

If you get tested in three to four months (*and you have not been exposed to the virus in the meantime*), and your results is still negative, you can probably assume that you are not HIV infected. The longest time between exposure and conversion from negative to positive reported to the Centers for Disease Control is 14 weeks.

#### **HOW CAN I KEEP FROM GETTING OR SPREADING THE VIRUS?**

- Know your sex partners. Ask questions about past sexual history and drug use. Be honest about your own past.
- Practice "safer sex:" use a condom for vaginal, anal, and oral sex; don't allow your partner's blood, semen, urine or feces to get into your vagina, anus, or mouth; don't allow your semen, blood, urine, or feces to get in your partner's vagina, anus, or mouth; don't share sex toys.
- Remember that condoms do not provide 100 percent protection against infection, and that anal intercourse (*even with a condom*) is more risky than oral or vaginal intercourse.
- Don't use injection drugs, but if you do, never share needles or syringes with anyone.
- See your doctor at least once a year.
- Don't share razors, toothbrushes, or anything else that could be contaminated with blood or body fluids.

#### **TO SUMMARIZE: IF YOUR TEST IS NEGATIVE:**

- You probably have not been infected;
- Practice "safer sex";
- Get retested in three months after exposure;
- Get retested before you plan a pregnancy;
- You are not immune to the virus; avoid exposure.

CALL THE AIDS INFO-LINE FOR FURTHER INFORMATION:  
1-800-342-AIDS



## IF YOUR TEST IS POSITIVE . . .

### ANSWERS TO QUESTIONS ABOUT THE HIV ANTIBODY BLOOD TEST

#### DOES BEING POSITIVE MEAN I HAVE AIDS?

NO. A positive HIV test means that you have been infected with the HIV virus, and that your body's immune system has produced antibodies to that infection. The blood test does not diagnose AIDS. Because the virus can lie dormant for many years, the final result for people with a positive test is unclear. Some infected people will not go on to develop AIDS. Some will remain healthy. Other will have an AIDS-related illness (ARC) which is usually fatal. Some people will in fact go on to develop AIDS.

A POSITIVE TEST MEANS THAT YOU CAN INFECT OTHERS, but only in certain ways:

- Through intimate sexual contact; or
- Through sharing needles when using drugs; or
- A mother can infect her unborn or newborn infant.

There is no evidence that the virus is spread through casual contact. It is safe to go on working, go out with friends, eat with friends, eat in restaurants, hug your family and live with others. However, you must consider yourself contagious, and take steps to protect all sexual or injection partners from exposure to the virus.

#### COULD MY TEST BE WRONG?

Your sample was tested three times before the positive result was reported: twice with the ELISA test, and once with the Western blot test. The chances of a "false positive" depend on whether you practice behaviors that place you at highest risk for AIDS: 1) gay or bisexual men; 2) injection drug users who have shared needles; 3) people with hemophilia who received clotting factor; 4) heterosexuals with multiple sex partners; 5) people with symptoms of AIDS; or 6) sex partners of any of the groups listed above.

The combination of ELISA and Western blot tests is very accurate, especially among persons who practice high-risk behaviors. Although you may be sure about your own behavior, you cannot be certain about infection in even a single partner. If you suspect that you are not at risk, repeat the test. In the meantime, you must assume that you are positive, and take steps to protect your sex and/or needle-sharing partners.

#### SHOULD I SEE A DOCTOR TO FIND OUT IF I HAVE SIGNS OF AIDS?

Yes, if you notice any of the following signs or symptoms, your doctor should give you a thorough physical examination. Be sure he/she knows about HIV; this clinic can refer you to a doctor if you don't have one.

#### SYMPTOMS OF CONDITIONS RELATED TO AIDS:

- Swollen glands in your neck, armpits, or groin;
- White patches in your mouth;
- Unusual bruises or sores on your skin;
- Fever or diarrhea that lasts longer than three weeks;
- Weight loss, not due to exercise or dieting;
- Shortness of breath;
- Drenching sweats at night;
- Severe confusion or change in mental status.

IF YOU NOTICE ANY OF THESE SYMPTOMS, IT IS IMPORTANT TO SEE A DOCTOR AS SOON AS YOU CAN.

#### WHAT ELSE SHOULD I DO NOW?

- TELL YOUR SEX OR NEEDLE-SHARING PARTNERS that you are positive for the virus and urge them to get testing and counseling.
- PAY SPECIAL ATTENTION TO YOUR HEALTH: get enough sleep, exercise, and eat healthy food. STOP using illegal drugs of any kind, and NEVER share needles.
- FOLLOW THE "SAFER SEX" GUIDELINES to prevent infecting others, and to protect yourself from being exposed to more HIV virus or other Sexually Transmitted Diseases (STDs). Laboratory evidence indicates that HIV multiplies faster when the immune system is activated. This could mean that exposure to another infection could hasten the development of AIDS.
- GET A TUBERCULIN SKIN TEST through a clinic or physician.
- INFORM YOUR DENTIST and other health care providers of your state.



## **WHAT SEXUAL ACTIVITIES ARE CONSIDERED SAFE?**

Any activities that don't involve that sharing of body fluids (*semen, blood and vaginal fluids*) are considered safe. ALWAYS USE A CONDOM or insist that your partner use one for oral, anal or vaginal intercourse. Remember that a condom does not provide 100 percent protection against infection and that anal intercourse (*even with a condom*) is more risky than oral or vaginal intercourse. Don't use saliva, Vaseline, or other oils as a lubricant when you use condoms; use a water-base lubricant. Safer sex includes hugging, cuddling, mutual masturbation, massage and dry kissing. Any kind of sexual intercourse without a condom is considered unsafe.

## **ARE THERE OTHER WAYS TO PREVENT SPREADING HIV?**

Yes. Here they are:

- Don't donate blood, plasma, semen, body organs or tissue.
- Don't get tattooed.
- Don't share toothbrushes, razors, or any other implement contaminated with blood or body fluids.

REMEMBER . . . WE WILL KEEP YOUR TEST RESULTS CONFIDENTIAL, AND IT IS UP TO YOU TO PROTECT OTHERS FROM GETTING AIDS THROUGH SEXUAL OR NEEDLE CONTACT.

CALL THE AIDS INFO-LINE FOR FURTHER INFORMATION:  
1-800-342-AIDS





**IMPORTANT NOTICE REGARDING REPLACEMENT OF INSURANCE**

*(Save this notice! It may be important to you in the future.)*

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one — or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

**STATEMENT TO APPLICANT BY AGENT OR BROKER:**

*(Use additional sheets, as necessary.)*

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?  No  Yes If "Yes," explain:

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2. Are there penalties, setup or surrender charges for the new policy?  No  Yes If "Yes," explain, emphasizing any extra cost for early withdrawal:

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3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  
 No  Yes If "Yes," explain:

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---



---

4. Are there adverse tax consequences from the replacement under current tax law?  No  Yes If "Yes," explain:

---



---



---

5. a) Are interest earnings a consideration in this replacement?  No  Yes

b) If "Yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings and the reduction of earnings that may result from setup charges, policy fees and other factors:

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---



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6. Are minimum amounts required to be on deposit before excess interest will be paid?  No  Yes If "Yes," explain:

---



---



---



7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
- a) Are the interest rates quoted  before or  after fees and mortality charges have been deducted?
  - b) Interest rates are guaranteed for how long? \_\_\_\_\_
  - c) The minimum interest rate to be paid is how much? \_\_\_\_\_
  - d) If applicable, the rate you pay to borrow is \_\_\_\_\_, and the limit on the amount that can be borrowed is \_\_\_\_\_.
  - e) The surrender charges are \_\_\_\_\_.
  - f) The death benefit is \_\_\_\_\_.

8. Are there other short or long-term effects from the replacement that might be materially adverse?

No  Yes If "Yes," explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Agent or Broker

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Name of Agent or Broker (print or type)

\_\_\_\_\_  
Address

**LIST OF POLICIES OR CONTRACTS TO BE REPLACED**

| Company | Insured | Policy or Contract Number |
|---------|---------|---------------------------|
| _____   | _____   | _____                     |
| _____   | _____   | _____                     |

**CAUTION:** The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing agent or company. Such advice might be helpful.
- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: \_\_\_\_\_

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

**THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.**

**To be completed if replacing another policy**

**Signed form to be returned to home office**

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





**IMPORTANT NOTICE REGARDING REPLACEMENT OF INSURANCE**

*(Save this notice! It may be important to you in the future.)*

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one — or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

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*(Use additional sheets, as necessary.)*

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?  No  Yes If "Yes," explain:

---



---



---

2. Are there penalties, setup or surrender charges for the new policy?  No  Yes If "Yes," explain, emphasizing any extra cost for early withdrawal:

---



---



---

3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  
 No  Yes If "Yes," explain:

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---

4. Are there adverse tax consequences from the replacement under current tax law?  No  Yes If "Yes," explain:

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---



---

5. a) Are interest earnings a consideration in this replacement?  No  Yes

b) If "Yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings and the reduction of earnings that may result from setup charges, policy fees and other factors:

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---



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6. Are minimum amounts required to be on deposit before excess interest will be paid?  No  Yes If "Yes," explain:

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7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
- a) Are the interest rates quoted  before or  after fees and mortality charges have been deducted?
  - b) Interest rates are guaranteed for how long? \_\_\_\_\_
  - c) The minimum interest rate to be paid is how much? \_\_\_\_\_
  - d) If applicable, the rate you pay to borrow is \_\_\_\_\_, and the limit on the amount that can be borrowed is \_\_\_\_\_.
  - e) The surrender charges are \_\_\_\_\_.
  - f) The death benefit is \_\_\_\_\_.

8. Are there other short or long-term effects from the replacement that might be materially adverse?

No  Yes If "Yes," explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Agent or Broker

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Name of Agent or Broker (print or type)

\_\_\_\_\_  
Address

**LIST OF POLICIES OR CONTRACTS TO BE REPLACED**

| Company | Insured | Policy or Contract Number |
|---------|---------|---------------------------|
| _____   | _____   | _____                     |
| _____   | _____   | _____                     |

**CAUTION:** The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing agent or company. Such advice might be helpful.
- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: \_\_\_\_\_

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

**THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.**

**To be completed if replacing another 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                                       |   | (      )<br>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<br>(if different from Insured or Annuitant) | Social Sec. or Tax I.D. No.                                   | Joint Owner's Full Name<br>(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.

|  |  |                              |
|--|--|------------------------------|
| ____ / ____ / ____<br><i>Date (MM/DD/YYYY)</i> | _____<br><i>Signature of Contract Owner</i>              | _____<br><i>Printed Name</i> |
| ____ / ____ / ____<br><i>Date (MM/DD/YYYY)</i> | _____<br><i>Signature of Joint Owner (if applicable)</i> | _____<br><i>Printed Name</i> |

|                                    |   |
|------------------------------------|---|
| <b>SIGNATURE GUARANTEE</b><br><br> | <b>ASSURITY LIFE INSURANCE COMPANY</b><br><br>By _____<br><br>Title _____ |
|------------------------------------|---|

