



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

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

Arizona Application for Critical Illness Insurance

This application includes all forms needed to apply for Critical Illness Insurance.

This application does not include the Life or Disability Income section(s).

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

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

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

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

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

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

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

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

All other applications should coincide with the **state where the application is signed**. State specific applications and state forms can be found on AssureLINK.

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state coinciding with the application used**.
- ✓ Print the application in black ink for faxing and photocopying purposes.
- ✓ Please verify that all questions on the application are answered. Obtain all required signatures.
- ✓ Have the Proposed Insured initial any changes. (Corrections with white correction fluid/tape are not acceptable.)
- ✓ Comply with all state regulations
 1. NAIC Model Illustration or disclosure statement must accompany any whole life application.
 2. Complete all other pertinent and applicable forms padded together in this application.

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

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

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



1. PROPOSED INSURED

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

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

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

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

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

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

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

4. PREMIUM PAYMENT MODE

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

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



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



GENERAL SECTION

Please answer the following questions:

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

2. During the past **5 years** or within the next **12 months** (If YES to any of the following, please complete and return the Avocation Questionnaire):
 a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured contemplating flying as a pilot, crew member or student? Yes No
 b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? Yes No
 If YES, check all that apply: Skin/Scuba Diving Bungee Jumping Skydiving/Parachuting/Hang Gliding
 Motor-powered Racing Boxing Rodeo Professional, Semi-professional or Club Sports
 Cave Exploration Mountain/Rock/Ice Climbing Hot Air Ballooning

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

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

5. During the past **5 years**, has any Proposed Insured:
 a. Had a life, health or hospital expense insurance application postponed, rated up, rideder 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, and applying for health coverage, please complete and return the appropriate State Replacement Form.

10. Does any Proposed Insured have other insurance coverage in force? Yes No
 If YES, please provide details below. If applying for life coverage, complete and return the appropriate State Replacement Form.

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



HEALTH SECTION

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

1. Has any Proposed Insured **ever** consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
- a. Heart disorder, including a heart attack (*myocardial infarction*), angina, irregular heartbeat or abnormal heart rhythm (*arrhythmia*), chest pain, hypertension (*high blood pressure*), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (*TIA or mini-stroke*), or rheumatic fever? Yes No
 - b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease (*other than kidney stones*), 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? Yes No
 - c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? Yes No
 - d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (*including Down's syndrome*), multiple sclerosis (*MS*), muscular dystrophy (*MD*), Parkinson's disease, amyotrophic lateral sclerosis (*ALS*), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy?..... Yes No
 - e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (*COPD*), shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (*lupus or scleroderma*)? Yes No
 - f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? Yes No
 - g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? Yes No
 - h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? Yes No
 - i. Any disease or disorder of the eyes, ears, nose or throat? Yes No
 - j. Any other illness or injury requiring medical attention or blood transfusions? Yes No

2. During the past **5 years**, has any Proposed Insured:
- a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?..... Yes No
 - b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? Yes No
 - c. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? Yes No
 - d. Been advised to have any test (*except HIV tests*), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received?..... Yes No
 - e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related blood tests*) or urine tests? Yes No

3. Has any Proposed Insured **ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*); or had a positive test for human immunodeficiency virus (*HIV*) antibodies? Yes No

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. Yes No
- _____

5. a. Has any Proposed Insured **ever** had any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? Yes No
- b. Is any Proposed Insured currently pregnant? Yes No
- If YES, date child is expected (MM/DD/YYYY) _____ / _____ / _____

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



CRITICAL ILLNESS HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details in #7 below.

1. Has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following:
 - a. Heart attack, stroke, elevated or abnormal cholesterol, angina, coronary heart disease, disease of the blood vessels or TIA (*transient ischemic attack*)? Yes No
 - b. Thyroid disorder, hepatitis, hepatitis carrier, anemia, fatigue, disorder of the pancreas, any lupus or any other blood or glandular disorder? Yes No
 - c. Polyp, mole, lump, other growth, breast disorder or abnormal mammogram, biopsy or abnormal prostate specific antigen (PSA) test? Yes No
2. Does any Proposed Insured regularly take any prescription medications? If YES, specify type and daily dosage in #7 below. Yes No
3. During the past **5 years**, has any Proposed Insured consulted any physician for any reason not detailed above? Yes No
4. Is any Proposed Insured aware of any symptoms or complaints regarding their health for which they have not yet consulted a physician?.... Yes No
5. Has any Proposed Insured been advised to have surgery, treatment or testing which has not been completed? Yes No
6. Has any Proposed Insured ever used marijuana or any illegal or addictive drugs? Yes No

7. **DETAILS:** Enter complete details from questions #1-6 below. If additional space is needed, attach a separate sheet of paper.

Question #/Letter	Name (First, Middle Last)	Relationship to Insured	Date of Condition (MM/DD/YYYY)	Health Condition & Details	Medical Care Provider's Name/Address/Phone
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		

8. Has any immediate family member (*whether living or dead*) of any Proposed Insured ever suffered from, or is currently suffering from: cancer, heart disease, stroke, kidney disease, diabetes, ALS (*amyotrophic lateral sclerosis or Lou Gehrig's disease*), motor neuron disease, Alzheimer's disease, Parkinson's disease or any other hereditary disease prior to age 65? If YES, please provide details below. If additional space is needed, attach a separate sheet of paper. Yes No

Name (First, Middle, Last)	Family Member/ Relationship	Diagnosis	Age at Time of Diagnosis



PRIMARY PHYSICIAN INFORMATION

Name _____
First Middle Last

Address _____
Street Address Suite

_____ *City State ZIP+4*

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

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

Results _____

AGREEMENT

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

I (We) agree that:

- a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Conditional Receipt delivered by the Company's agent in exchange for such payment.
- b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Conditional Receipt or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

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

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

Signature of Proposed Insured

Signature of Additional Proposed Insured

Signature of Additional Proposed Insured

Signature of Parent/Guardian of Minor Child

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

Signature of Beneficiary (If applying for Reversionary Annuity)

Signature of Licensed Agent

Print Agent Name and Agent No.





Name of Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Name of Additional Applicant/Insured/Claimant (Please print)

_____/_____/_____
Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant Child(ren)			
Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

I, on behalf of myself or the person named above (*Individual*), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, 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)





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)



CONDITIONAL RECEIPT
Please Read Carefully!

TERMS AND CONDITIONS - Coverage issued bearing the date of this receipt will become effective on

- the later of the date of the application; or
- the date of completion of Part 2 – Critical Illness Section of the application; or
- the date of completion of the last medical requirements or tests required.

Coverage will be provided when the following conditions are met:

1. The application and complete evidence of insurability is received at our Home Office.
2. The Proposed Insured for coverage is insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid on the date of application. The maximum amount of critical illness insurance, which will become effective under this receipt, will be the lesser of the amount of insurance applied for or \$50,000. This includes any pending critical illness insurance with Assurity Life Insurance Company.

If any check, draft, money-order or other instrument tendered in payment of the amount specified hereof is not paid or honored, the said amount shall be considered unpaid and this receipt and acknowledgement of payment shall be null and void.

No conditional receipt coverage will have been in effect if any of the following apply:

- a) the application is declined; or
- b) the full first premium has not been paid; or
- c) the policy is not issued exactly as applied for; or
- d) there is insufficient evidence of insurability; or
- e) the application is not approved within sixty days of its completion.

Any premium paid and not used to issue a policy of Critical Illness Insurance will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

ASSURITY LIFE INSURANCE COMPANY

PLAN _____ Amount \$ _____

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

Agent's Signature Date: _____

I agree to the terms of the Conditional Receipt set out above.

Signature of the Proposed Insured Date: _____

Signature of the Owner (if other than Proposed Insured)



MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Assurity or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

Insurance Information Practices

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

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

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

Fair Credit Reporting Act

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

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

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

Telephone Interview Information

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





BLOOD TESTING MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

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

CONSENT FOR HIV TESTING

To evaluate your insurability, the insurer named above (*the Insurer*) has requested that you provide a sample of your blood or urine for testing and analysis to determine the presence of Human Immunodeficiency Virus (*HIV*) antibodies. By signing and dating this form, you agree that this test may be performed and that underwriting decisions will be based on the test results. You may have ten (10) days to decide whether you wish to sign this form. You may refuse to be tested. However, such refusal may be used by the Insurer as a reason to deny coverage.

PRE-TEST COUNSELING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV antibody/antigen test, a person seek counseling to become fully informed concerning the implications of such test. You may wish to consider obtaining such counseling, at your own expense, prior to being tested. Free confidential counseling is available in most Arizona communities. If you need information about the availability of counseling in your area, contact your county health department or:

Phoenix Metropolitan area: 253-2437
(*Arizona AIDS Information Line*)

Outside the Phoenix area: 1-800-334-1540
(*Arizona Department of Health Services*)

INFORMATION ON HIV

The Human Immunodeficiency Virus (*HIV*) is the virus that causes Acquired Immune Deficiency Syndrome (*AIDS*). HIV is spread through the exchange of blood (*including transfusion*), sexual fluids (*semen and vaginal secretions*) and sometimes through breast milk. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.

Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (*male or female*); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers. HIV can be transmitted from mother to baby during pregnancy or childbirth.

HIV TESTING

There are several laboratory tests for HIV. The most common is the antibody test, which is a blood test that detects antibodies produced by the body in response to infection with HIV.

A positive antibody test consists of repeatedly reactive (*the same specimen testing positive twice*) enzyme immunoassay (*EIA*) and a reactive Western blot (*supplementary test*). A positive antibody test means that an individual is infected with HIV; however, this does not always mean that the individual has AIDS. Research indicates that early and regular medical care is important to the health of a person with HIV. Certain treatments are now available to delay HIV-associated illnesses.

A negative antibody test indicates that no detectable antibodies are present in the blood. An individual may not have antibodies because the individual is not infected with HIV or because detectable antibodies have not yet been made in response to infection. The production of these antibodies could take three months or longer. Therefore, in certain cases, an individual may be infected with HIV and yet test negative. Individuals with a history of HIV risk behaviors within the past three to six months should consider retesting.

Like any test, HIV testing is not 100 percent reliable and may occasionally produce both false positive and false negative results.



MEANS TO REDUCE RISK FOR CONTRACTING OR SPREADING HIV

Risk of contracting or spreading HIV can be reduced by avoiding or decreasing contact with blood and sexual fluids (*semen and vaginal secretions*). Some methods of decreasing the risk of contracting or spreading HIV include abstaining from sexual intercourse, using methods that limit exposure to body fluids during intercourse (*such as the proper use of condoms*), not engaging in injecting drug use, not sharing needles, or using bleach and water to clean needles and syringes.

DISCLOSURE OF TEST RESULTS

All test results are required to be treated confidentially. The results of this test will be reported to the Insurer identified on this form. Results of this test will not be otherwise disclosed without your written consent except as required or allowed by law, including but not limited to, the release of information to the Department of Health Services as provided by law.

ADDITIONAL SOURCES OF INFORMATION ON HIV

Additional information regarding testing for HIV is available through your county health department and, in the Phoenix metropolitan area at 602-234-2752, the Tucson metropolitan area at 520-326-2437, or outside the Phoenix area at 1-800-334-1540. National Hotline: English, 1-800-342-2437; Spanish, 1-800-344-7432; TTY/TDD, 1-800-243-7012.

CONSENT

I have been given the opportunity to ask questions regarding this information and have had my questions answered to my satisfaction. I understand that this test can be performed anonymously at a public health agency. I also understand that I may withdraw my consent at any time before a blood or urine sample is taken in order to conduct a test, and that I may be asked to put my decision to withdraw my consent in writing if I have signed this consent form. I also understand that this is a voluntary test and that I have a right to refuse to be tested. I understand that I have a right to request and receive a copy of this form. A photocopy of this form will be as valid as the original. I understand that this consent shall be valid for 180 days following the date shown below.

My signature below indicates that I have received and understand the information I have been given and I voluntarily consent to and request HIV testing.

_____	_____
<i>Proposed Insured (Printed)</i>	<i>Date of Birth (MM/DD/YYYY)</i>
_____	_____
<i>Signature of Proposed Insured or Legal Representative</i>	<i>Date (MM/DD/YYYY)</i>
_____	_____
<i>Signature of Witness</i>	<i>Date (MM/DD/YYYY)</i>

OPTIONAL RELEASE OF INFORMATION TO PERSONAL PHYSICIAN

In addition to the release of information as described above, I hereby authorize the release of my HIV test results to my personal physician named below:

Physician's Name _____

Physician's Address _____

_____	_____
<i>Signature of Proposed Insured or Parent/Guardian</i>	<i>Date (MM/DD/YYYY)</i>



