



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

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

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



**1. PROPOSED INSURED**

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

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

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

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

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

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

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

**4. PREMIUM PAYMENT MODE**

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

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





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





## GENERAL SECTION

Please answer the following questions:

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

2. During the past **5 years** or within the next **12 months** (If YES to any of the following, please complete and return the Avocation Questionnaire):

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

b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? .....  Yes  No  
 If YES, check all that apply:     Skin/Scuba Diving                       Bungee Jumping                       Skydiving/Parachuting/Hang Gliding  
 Motor-powered Racing                       Boxing                       Rodeo                       Professional, Semi-professional or Club Sports  
 Cave Exploration                       Mountain/Rock/Ice Climbing                       Hot Air Ballooning

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

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

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

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

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

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

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

a. Had their driver's license suspended or revoked, been convicted of or pleaded "guilty" or "no contest" to driving under the influence (DUI/DWI), or had more than 3 moving violations? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_

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

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

9. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? .....  Yes  No  
 If YES, please complete and return the appropriate State Replacement Form.

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

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



## HEALTH SECTION

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

1. Has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
- a. Heart disorder, including a heart attack (*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. During the past **20 years**, has any Proposed Insured 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 PRODUCT SECTION

Plan of Insurance: (Check one)     Critical Illness                       Other (Please specify) \_\_\_\_\_

Base Amount \$ \_\_\_\_\_

### ADDITIONAL BENEFITS (If available)

Check benefit(s) desired and indicate amount requested.

- Accidental Death Benefit Rider \$ \_\_\_\_\_                       Children's Term Insurance Rider
- Waiver of Premium Rider     Other (Please specify) \_\_\_\_\_ \$ \_\_\_\_\_
- Spouse Rider \$ \_\_\_\_\_     Other (Please specify) \_\_\_\_\_ \$ \_\_\_\_\_
- Additional Insured Rider(s) – Please complete the information below. If additional space is needed, attach a separate sheet of paper.

#### Additional Insured —Spouse

<i>First</i> <i>Middle</i> <i>Last</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name				
Social Security No.	Birth State/Country	Age	Date of Birth <small>(MM/DD/YYYY)</small> /   /	
Primary Employer			Height   ft.   in.	Weight   lbs.

#### Additional Insured —Child

<i>First</i> <i>Middle</i> <i>Last</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name				
Social Security No.	Birth State/Country	Age	Date of Birth <small>(MM/DD/YYYY)</small> /   /	
Primary Employer			Height   ft.   in.	Weight   lbs.

#### Additional Insured —Child

<i>First</i> <i>Middle</i> <i>Last</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name				
Social Security No.	Birth State/Country	Age	Date of Birth <small>(MM/DD/YYYY)</small> /   /	
Primary Employer			Height   ft.   in.	Weight   lbs.

#### Additional Insured —Child

<i>First</i> <i>Middle</i> <i>Last</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name				
Social Security No.	Birth State/Country	Age	Date of Birth <small>(MM/DD/YYYY)</small> /   /	
Primary Employer			Height   ft.   in.	Weight   lbs.

#### Additional Insured —Child

<i>First</i> <i>Middle</i> <i>Last</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name				
Social Security No.	Birth State/Country	Age	Date of Birth <small>(MM/DD/YYYY)</small> /   /	
Primary Employer			Height   ft.   in.	Weight   lbs.

#### Additional Insured —Child

<i>First</i> <i>Middle</i> <i>Last</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name				
Social Security No.	Birth State/Country	Age	Date of Birth <small>(MM/DD/YYYY)</small> /   /	
Primary Employer			Height   ft.   in.	Weight   lbs.

#### Additional Insured —Child

<i>First</i> <i>Middle</i> <i>Last</i>			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name				
Social Security No.	Birth State/Country	Age	Date of Birth <small>(MM/DD/YYYY)</small> /   /	
Primary Employer			Height   ft.   in.	Weight   lbs.



## 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:

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

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

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

Signed at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*City State Date (MM/DD/YYYY)*

\_\_\_\_\_  
*Signature of Proposed Insured*

\_\_\_\_\_  
*Signature of Additional Proposed Insured*

\_\_\_\_\_  
*Signature of Additional Proposed Insured*

\_\_\_\_\_  
*Signature of Parent/Guardian of Minor Child*

\_\_\_\_\_  
*Signature of Owner(s) (If other than Proposed Insured)*

\_\_\_\_\_  
*Signature of Beneficiary (If applying for Reversionary Annuity)*

\_\_\_\_\_  
*Signature of Licensed Agent*

\_\_\_\_\_  
*Print Agent Name and Agent No.*







\_\_\_\_\_  
*Name of Applicant/Insured/Claimant (Please print)*

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

\_\_\_\_\_  
*Name of Additional Applicant/Insured/Claimant (Please print)*

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

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

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





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

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

**EXAMINER:** \_\_\_\_\_

*Name*

*Address*

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

Tests may be performed to determine the presence of antibodies or antigen to the Human Immunodeficiency Virus (*HIV*), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (*fats*) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved in the underwriting and claims review process. Your test results will not be disclosed to your agent or broker. If the HIV test is positive, the results will be reported to the local health department or the State Department of Health, and if the insurer is a member of the Medical Information Bureau (*MIB, Inc.*) the Insurer may report the results in a generic code which signifies only nonspecific blood abnormalities. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results, or even that the tests have been done, except as may be required or permitted by law or authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer or your designated physician will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results.

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

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

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

In the event of a positive HIV test result, I authorize Assurity Life Insurance to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

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

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

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

\_\_\_\_\_  
*Proposed Insured (Printed)*

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

\_\_\_\_\_  
*Signature of Proposed Insured or Parent/Guardian*

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

\_\_\_\_\_  
*State of Residence*





**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application (*information you have furnished*), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Assurity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions that you may presently have (*pre-existing conditions*), may not be immediately or fully covered under the new policy, or the new policy may also provide for a waiting period for certain specified conditions. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

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

\_\_\_\_\_ *Applicant's Signature and Printed Name*

**Signed form to be returned to the home office.  
 Applicant to receive a copy of the signed form at the time the application is taken.**





**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

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\_\_\_\_\_ *Applicant's Signature and Printed Name*

**Signed form to be returned to the home office.  
 Applicant to receive a copy of the signed form at the time the application is taken.**





**ASSURITY LIFE INSURANCE COMPANY**  
1526 K Street, P.O. Box 82553  
Lincoln, Nebraska 68501-2533

**OUTLINE OF COVERAGE**  
**CRITICAL ILLNESS INSURANCE POLICY**  
**FORM NO. CI 007 (ID)**

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“We” are **Assurity Life Insurance Company**, the company providing this Outline of Coverage. The address is P.O. Box 82533, Lincoln, Nebraska, 68501-2533. We are required to give You the following information:

- **THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED. CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**
- **CAPITALIZED WORDS ARE USED AS DEFINED IN THE POLICY.**
- **RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.**
- **READ YOUR POLICY CAREFULLY.** This Outline of Coverage gives a summary of the important features of Your Policy. This is not the insurance contract. Only the actual Policy provisions will control. The Policy details both Your rights and obligations and Our rights and obligations as Your insurance company.
- **CRITICAL ILLNESS COVERAGE** is designed to provide You with a lump sum payment if You are diagnosed for the first time ever with one of the specified conditions or undergo for the first time ever one of the specified procedures named in the Policy. A limited benefit is paid for cancer in situ, coronary bypass and angioplasty. No Benefits are paid for basic hospital, medical-surgical, or major medical expenses. The following pages give a summary of the benefits, limitations, conditions and costs of Your Policy.

**THIS IS A LIMITED BENEFIT POLICY!**

**POLICY BENEFITS**

While Your Policy is in force, We will pay You the Benefit Amount if You receive a First Ever Diagnosis or Procedure for one of the following Specified Covered Conditions:

<b>Critical Illness Covered Condition</b>	<b>Percentage of Maximum Benefit Payable</b>
a) Invasive Cancer	100%
b) Heart Attack	100%
c) Stroke	100%
d) Accidental Loss of Speech	100%
e) Advanced Alzheimer's Disease	100%
f) Aortic Surgery	100%
g) Benign Brain Tumor	100%
h) Blindness	100%
i) Coma	100%
j) Deafness	100%
k) End-Stage Renal Failure	100%
l) Heart Valve Replacement/Repair Surgery	100%
m) Loss of Limbs	100%
n) Major Burns	100%
o) Major Organ Transplant	100%
p) Motor Neuron Disease	100%
q) Occupational HIV Infection	100%
r) Paralysis	100%
s) Angioplasty	25% up to a maximum of \$25,000
t) Cancer in Situ	25% up to a maximum of \$25,000
u) Coronary Bypass Surgery	25% up to a maximum of \$25,000

and;

If a portion of the Maximum Benefit Amount is paid under the Policy or certain attached Riders (if applicable), the Maximum Benefit Amount will be reduced by the amount paid, and the premium will be adjusted accordingly. The Owner will be notified of the new Maximum Benefit Amount and new Premium. In no event will the payment(s) for any Critical Illness Insured Condition(s) exceed the Maximum Benefit Amount then in force.

**Reduced Benefit After Age 65.** Beginning in the Policy year immediately following the Insured's 65th birthday or five years from the Policy Issue Date, which ever is later, the Maximum Benefit Amount then in force will be automatically reduced by 50%. This will be the Maximum Benefit Amount available for the remaining years the Policy is in force.

Definitions of each Specified Covered Condition or Procedure are found in Your Policy.

**LIMITATIONS**

- The Benefit Amount for Coronary Bypass Surgery and Cancer in Situ is 25% of the Maximum Benefit Amount. The Benefit Amount for Angioplasty is 25% of the Maximum Benefit Amount.
- For Invasive Cancer or Cancer in Situ, no Benefit Amount will be paid if the First Ever Diagnosis is made anytime within 30 days following the Issue Date or 10 days following the last Reinstatement date of the Policy.

**EXCLUSIONS**

We will not pay a Benefit Amount for a Specified Covered Condition or Procedure resulting from

- participating in or attempting to commit a felony;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide, whether sane or insane; or
- involvement in a war or act of war, whether declared or not.

## **PREMIUMS**

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The first Premium is due on the Date of issue. Premiums due after the first Premium are Renewal Premiums. Renewal Premiums are paid at the Premium payment interval. You can change this. The date the next Renewal Premium is due is the Due Date. Renewal Premiums are paid before the Due Date. If You terminate Your Policy for any reason, any unearned Premium will be refunded to You.

You have a Grace Period to pay Renewal Premium payments. The Grace Period starts on the Due Date and ends 31 days later. During the Grace Period, Your Policy stays in force. If You do not pay the Renewal Premium by the end of the Grace Period, Your Policy will end for non-payment of Premium.

If Your Policy ends because You did not pay a Renewal Premium, You can ask to have the Policy put back in force. This is called Reinstatement. You must ask for Reinstatement within 2 years of the lapse of Your Policy. We will decide if the Policy is put back in force. The Reinstated Policy will only pay a Benefit Amount for First Ever Diagnosis of Covered Specified Diseases or Procedures that happen after the Policy has been put back in force.

## **RENEWABILITY**

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This Policy is Guaranteed Renewable for life. That means We cannot cancel or change Your Policy as long as You pay Premiums. We can change the Premium rates. If We do this, We can only do it to all Policies in Your class, with Your state's approval.

## **RIGHT TO CANCEL**

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You may cancel the Policy within 30 days of receiving it. Return the Policy to Assurity's Home Office or Your Assurity sales agent. As soon as You deliver or mail the Policy to Us, it is treated as if it was never issued. We will give back Your Premium payment. After the first 30 days, You may cancel this Policy at any time by telling Us in writing. The Policy will be cancelled on the date We receive Your written notice or the date You tell Us in Your notice. We will give back any unearned Premium.

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