

# Juvenile Insurance Application to Assurity Life Insurance Company

1526 K Street • P.O. Box 82533 • Lincoln, Nebraska 68501-2533

## General Section – Proposed Insured Child should be Age 14 ½ or younger.

I hereby apply for insurance with Assurity Life Insurance Company to be issued in reliance upon the following statements which I represent to be complete and true to the best of my knowledge and belief:

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

### Please Print

1. (A) Child's Full First Name		Middle Initial	Last Name	(B) Social Security Number	(C) Sex <input type="checkbox"/> M <input type="checkbox"/> F
(D) Date of Birth Month Day Year	(E) Age Nearest Birthday	(F) Height	Weight	(G) Weight change in past year _____ lbs. <input type="checkbox"/> loss <input type="checkbox"/> gain	(H) Birth State

2. Residence: \_\_\_\_\_  
Street City State Zip Code

3. (A) Applicant's Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

(B) Applicant's mailing address: \_\_\_\_\_  
Street City State Zip Code

(C) Applicant's Social Security Number: \_\_\_\_\_ (D) Applicant's Date of Birth: \_\_\_\_\_

4. (A) Owner's Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

(B) Owner's mailing address: \_\_\_\_\_  
Street City State Zip Code

(C) Owner's social Security Number: \_\_\_\_\_ (D) Owner's Date of Birth: \_\_\_\_\_

(\*If no other Owner is designated, the Applicant shall be the Owner.)

5. Contingent Owner's Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

6. If this insurance is issued, will it replace any insurance, annuity or other policy? .....  Yes  No

If "Yes," please complete: Policy Number: \_\_\_\_\_

Name and address of company being replaced: \_\_\_\_\_

(Send the appropriate replacement forms with the application.)

7. Are you negotiating for other insurance coverage? .....  Yes  No

If "Yes," please explain: \_\_\_\_\_

8. If Payor Benefit Provision is applied for, complete this section and Questions 9-13 on the Applicant

(A) Occupation and duties: \_\_\_\_\_

(B) Employer name and address: \_\_\_\_\_

(C) Height and weight: \_\_\_\_\_ (D) Place of birth: \_\_\_\_\_

**General Section (Continued)** If medical exam required due to amount applied for, you may omit answering Questions 9-13 on the Child. If Payor Benefit is applied for, Questions 9-13 must be answered on the Applicant also.

9. Have the Child or Applicant (if the Payor Benefit Provision is applied for) ever been treated for, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following? If "Yes," complete #10 below.
- A. Dizziness, fainting spells, epilepsy, depression, anxiety, mental disorder, or any disease or disorder of the brain or nervous systems? .....  Yes  No
  - B. Asthma, bronchitis, tuberculosis, pneumocystis, or any disorder of the lungs or respiratory system? .....  Yes  No
  - C. High blood pressure, chest pain, shortness of breath, heart murmur, rheumatic fever or any disease or disorder of the heart, hemophilia or coagulation disorder?.....  Yes  No
  - D. Any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder? .....  Yes  No
  - E. Any disease or disorder of the kidney, bladder or prostate?.....  Yes  No
  - F. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles?.....  Yes  No
  - G. Diabetes, or sugar, albumin or blood in the urine? .....  Yes  No
  - H. Cancer or a tumor or cyst of any kind, or enlargement of lymph nodes? .....  Yes  No
  - I. Varicose veins, varicose ulcer or phlebitis, syphilis, or a hernia? .....  Yes  No
  - J. Any disease or disorder of the eyes, ears, nose or throat? .....  Yes  No
  - K. Any advice or treatment for alcoholism, drug addiction, drug abuse or other substance abuse?.....  Yes  No
  - L. Have you ever received medical diagnosis of, or tested positive for AIDS (Acquired Immunological Deficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder?.....  Yes  No
  - M. Any other illness or injury requiring blood transfusion or other medical attention? .....  Yes  No
  - N. Any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests other than AIDS related blood tests, or urine tests during the past 5 years? .....  Yes  No

10. If any questions in #9 are answered "Yes," indicate the question number and give complete details.

No.	Name of Person	Condition	Onset Date	Duration	Names, Addresses and Phone #'s of all Physicians, Hospitals and Medical Facilities

11. Name, address, phone and fax # of Child's regular physician:  <div style="text-align: right;">           Fax:            Phone:         </div>	Date last consulted:
	Reasons and results:

12. Name, address, phone and fax # of Applicant's regular physician:  <div style="text-align: right;">           Fax:            Phone:         </div>	Date last consulted:
	Reasons and results:

13. Child's Family History	Age	State of Health	Age at Death	Cause
Father				
Mother				
Brothers and Sisters				
No. living:				
No. deceased:				

## Traditional Product Life Section/Flexible Premium Universal Life Section

14. What is the total amount of life insurance (personal and business) in force on your life and the child's life? Include coverage under any term riders and accidental death benefits under accident insurance policies. If "None," so state.

Company	When Issued	Amount	ADB Amount
Applicant:			
Child:			

**Traditional Product Life Section:**

15. Plan of Insurance \_\_\_\_\_ Amount of Base Plan \$ \_\_\_\_\_  
 If cash value is available, should the Automatic Premium Loan Provision be made effective?.....  Yes  No
16. Additional Benefits (if available). Check benefit(s) desired and indicate amount requested.  
 Payor Benefit  Additional Deposit Privilege Endorsement  
 Accidental Death Benefit (Age 10 and over)  Protected Insurability Rider \_\_\_\_\_ units  
 VER  Periodic \$ \_\_\_\_\_ premium  Single \$ \_\_\_\_\_ premium  Other \_\_\_\_\_
17. Dividend Option: (If none chosen, policy provisions determine option.) \_\_\_\_\_

**Universal Product Life Section:**

18. Plan of Insurance \_\_\_\_\_ Face Amount \$ \_\_\_\_\_
19. Planned Premium (Amount to be billed or deposited each payment period): \$ \_\_\_\_\_
20. Death Benefit Option:  Option One (Face Amount)  Option Two (Face Amount plus Cash Value)
21. Additional Benefits (if available). Check benefit(s) desired and indicate the amount requested.  
 Accidental Death Benefit \$ \_\_\_\_\_ amount (Age 10 and over)  Protected Insurability Rider \_\_\_\_\_ units  
 Payor Benefit

**Mode of Payment:**

22. How shall premiums be payable?  Annually  Semi-annually  Quarterly  PAC  Other \_\_\_\_\_

**Beneficiary:**

23. The Primary Beneficiary or Beneficiaries who survive the Child by 120 hours shall share equally unless otherwise indicated.  
 A. Primary Beneficiary and relationship to Child: \_\_\_\_\_  
 If no Primary Beneficiary survives the Proposed Insured by 120 hours, benefits will be paid in equal shares to the contingent Beneficiaries, if surviving the Proposed Insured by 120 hours, unless otherwise specified.  
 B. Contingent Beneficiary and relationship to Child: \_\_\_\_\_

**I (WE) AGREE THAT:**

- A. 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 (General Section and Traditional Product Life Section/Flexible Premium Universal Life Section and Answers Made to the Medical Examiner, if required) shall form a part of the policy if attached thereto.
- B. 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.
- C. 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 the application is approved by Assurity at its Home Office, such policy issued and delivered to the Applicant/Owner, and such first full premium paid during the Child's lifetime and continued good health and the lifetime and continued good health of any other person(s) covered under the policy, and when such approval, issue, and delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- D. In no event shall the insurance on the Child's life take effect until the Child is 15 days old.
- E. No agent or medical examiner has the power or is authorized 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.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, Year , \_\_\_\_\_.

Witnessed by \_\_\_\_\_ X \_\_\_\_\_  
Licensed Resident Agent Signature of Applicant

Agency Number \_\_\_\_\_ X \_\_\_\_\_  
Signature of Owner if not Applicant

X \_\_\_\_\_  
Signature of Child

# Field Underwriter's Statement

1. A. What amount was collected with this application? \$ \_\_\_\_\_  
B. Has a Conditional Receipt been given to the Applicant/Owner? .....  Yes  No  
C. Has an Authorization for Release of Medical Information been signed and Fair Credit and MIB notification been given? .....  Yes  No
2. A. Did you personally see all persons to be insured on date of application? .....  Yes  No  
If "No," please explain in # 7 below.  
B. How well do you know the Proposed Insured?  Well  Slightly  Relative  Not at all  
C. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? .....  Yes  No  
If "Yes," please explain in # 7 below.  
D. Is the Proposed Insured a citizen of the United States? .....  Yes  No  
If "No," provide type of visa, number, and expiration date below:
3. Is the application being submitted on a non-medical basis? .....  Yes  No  
If "No," check items for which arrangements have been made:  
 Medical exam by physician with Home Office specimen
- Name and address of examiner: \_\_\_\_\_  
Date above items to be completed: \_\_\_\_\_
4. All life cases require a signed illustration be submitted with the application or a signed Illustration Disclosure Statement.  
5. If this insurance is issued, will it replace any insurance, annuity or other policy? .....  Yes  No  
If "Yes," please explain in # 7 below.
6. I hereby certify that to the best of my knowledge and belief the answers on the application and in this statement are true and correct.

_____	_____	_____
Soliciting Agent Signature	Code Number	Date
_____	_____	_____
Soliciting Agent Printed Name	Agent Business Phone No.	Agent Fax No.

7. Special requests, remarks and instructions:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Referrals – Name: \_\_\_\_\_  
Name: \_\_\_\_\_
9. Pre-Authorized Check (PAC) – Special monthly rate is 8.8% of annual premium.  
 New PAC – Signed authorization and deposit slip needed with application. Applications and/or policies \_\_\_\_\_  
\_\_\_\_\_ to be included on the PAC.  
 Add to existing PAC on: \_\_\_\_\_  
 List Billing – Set up new billing to: (full Name and Address of Company) \_\_\_\_\_  
\_\_\_\_\_  
 List Billing – Add to existing billing number \_\_\_\_\_ to: Name of Company: \_\_\_\_\_  
\_\_\_\_\_

10. Was this application faxed to the Home Office?  Yes  No  
If "Yes," date faxed: \_\_\_\_\_

For Home Office use only: Date Received \_\_\_\_\_ Policy # \_\_\_\_\_ CWA \$ \_\_\_\_\_



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

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

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

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

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

I, on behalf of myself or the person named above (*Individual*), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company (*Assurity*), its reinsurers and/or consumer reporting agencies and their authorized representatives (*provided, however, consumer reporting agencies may not collect information under this authorization from the MIB*):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases (**Except information about human immunodeficiency virus (*HIV*) infection for Individuals residing in Maine or Vermont.** **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four (24) months from the date of signature below (**Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

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

\_\_\_\_\_  
*Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

\_\_\_\_\_  
*Signature of Additional Applicant/Insured/Claimant or Legal Representative*

\_\_\_\_\_  
*Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

\_\_\_\_\_  
*Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)*





## MIB Pre-Notice

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

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

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

## Insurance Information Practices

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

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

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

## Fair Credit Reporting Act

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

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

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

## Telephone Interview Information

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



## Conditional Receipt

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

The following Conditional Receipt is issued by Assurity Life Insurance Company when the full initial premium is collected from the Proposed Insured/Owner at the time the application is completed. The full initial premium may be collected when the amount of in-force and applied for individual life coverage, including the present value of future benefits of any reversionary annuity policy, with Assurity Life Insurance Company does not exceed \$500,000. This \$500,000 limit applies to applications on which the Proposed Insured has fully and accurately answered all health questions indicating no significant health problems. Individual life applications may be accepted without the health questions answered if the Proposed Insured is to be medically examined. However, in these cases, the full initial premium can be collected only when the in-force and applied for coverage, including the present value of future benefits of any reversionary annuity policy, does not exceed \$100,000 with Assurity Life Insurance Company. The full initial premium may also be collected for individual disability coverage when the amount of in-force and applied for individual disability coverage (base policy Monthly Benefits plus SDIR Monthly Benefit) with Assurity Life Insurance Company does not exceed \$2,500 per month. Applications with in-force and applied for amounts that exceed these limits, or where the Proposed Insured has significant health problems, must be handled on a Cash On Delivery (C.O.D.) basis.

In addition to the above insurance limits, issuing a Conditional Receipt requires **full modal payment** (including PAC authorization and sample check for PAC mode, if applicable). A Conditional Receipt may **not** be issued in exchange for a postdated check or a partial premium payment. **Payment in this manner in no way conditionally binds Assurity Life Insurance Company.**

Following the Conditional Receipt are two notices required to be given to the Proposed Insured. The federal **Fair Credit Reporting Act** notice explains the nature of investigative consumer reports, and explains the Proposed Insured's rights if such a report is requested. The disclosure regarding the **Medical Information Bureau (MIB)** informs the Proposed Insured of restrictions on obtaining and disclosing confidential medical information.

# Conditional Receipt

## Assurity Life Insurance Company • Lincoln, Nebraska

The Proposed Insured/Owner's payment of the full initial premium and acceptance of this Conditional Receipt constitutes the Proposed Insured/Owner's acceptance of its terms and conditions. Unless all terms and conditions are fulfilled exactly, no insurance will become effective prior to policy delivery. In all events, any insurance provided is subject to the stated limits. No agent is authorized to change or waive any conditions or limits. Please make **all** premium checks payable to "Assurity Life Insurance Company". Please **do not** make checks payable to the agent or leave "payee" blank.

1. The sum of \$ \_\_\_\_\_ is received of \_\_\_\_\_ by Assurity Life Insurance Company ("The Company") as payment of the full initial premium on insurance applied for on this date. Payment is accepted subject to the terms and limitations of this Conditional Receipt ("Receipt"). It is expressly understood and agreed that unless all conditions set forth in this Receipt are satisfied, or that unless the coverage applied for is issued within 60 days of the date of application, no insurance shall ever take effect. In such case, the Company's only liability and obligation is to promptly refund the premium payment received.
2. If, on the applicable date, the Proposed Insured was acceptable for the plan and amount of insurance applied for, without modification, under Assurity's rules, limits and standards of insurability, coverage will be effective the later of i) the date of application, or ii) the date any medical examination of the Proposed Insured is completed, if required by the Company. Insurance will be issued at Assurity's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.
- 3a. Assurity Life Insurance Company has NO liability for life insurance coverage if the answers to the health questions on the application indicate any significant health problems. Otherwise, the Company's total life insurance liability, including the present value of future benefits for any reversionary annuity policy, for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company, including the present value of future benefits for any reversionary annuity policy, on the Proposed Insured's behalf (including that for which this Receipt is given) shall not exceed \$500,000 if all application health questions are answered, and shall not exceed \$100,000 if no application health questions are answered.
- b. Assurity Life Insurance Company has NO liability for health insurance coverage and this Receipt is void for any insurance if any health questions on the application have not been answered and no medical examination is required of the Proposed Insured. Otherwise, the Company's total health insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that which this Receipt is given) shall not exceed \$2,500 per month.  
  
These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.
4. This Receipt must not be detached and used unless the full amount of the first premium is paid on the date of the application. Payment cannot be accepted with the application if any person proposed for coverage has been treated for or had any known heart trouble, stroke or cancer within the past twelve months. This Receipt is void if exchanged for any check or draft that is not honored upon first presentation for collection through usual banking facilities.

Dated: \_\_\_\_\_

Agent: \_\_\_\_\_



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**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>





**IMPORTANT NOTICE**

**This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.**

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by withdrawal, surrender or borrowing of some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs, and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating your existing policy or contract?  Yes  No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?  Yes  No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (*include the name of the insurer, the insured or annuitant, and the policy or contract number if available*) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

\_\_\_\_\_

I certify that the responses herein are, to the best of my knowledge, accurate:

<i>Applicant's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>
<i>Producer's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>

**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.**



I do not want this notice read aloud to me. \_\_\_\_\_ (*Applicant must initial only if they do not want the notice read aloud.*)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

### **PREMIUMS**

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

### **POLICY VALUES**

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

### **INSURABILITY**

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

### **IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY**

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

### **IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT**

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

### **OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS**

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (*See your tax advisor.*)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

**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.**



## **ILLUSTRATION DISCLOSURE STATEMENT**

Proposed Insured's Knowledge and Agent's Certification of

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

### **PROPOSED INSURED ACKNOWLEDGEMENT**

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

\_\_\_\_\_  
Proposed Insured's Signature

\_\_\_\_\_  
Date

### **AGENT CERTIFICATION**

I certify that:

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

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

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

\_\_\_\_\_  
Agent Signature

\_\_\_\_\_  
Date



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

**Applicant/Owner Name** \_\_\_\_\_ **Social Security No.** \_\_\_\_\_ — —

**1. Source of Funds**

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

**2. Intended purpose of applied for coverage**

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

**3. Applicant's background**

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

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

\_\_\_\_\_  
 \_\_\_\_\_

**5. Source of information**

Name \_\_\_\_\_

- Applicant
- Owner
- Payor
- Other (specify) \_\_\_\_\_

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

\_\_\_\_\_  
*Producer Signature*

\_\_\_\_\_  
*Producer No.*

\_\_\_\_\_  
*Producer Name*

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

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



