

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)			
<i>Name</i>	<i>Date of Birth</i>	<i>Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

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

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

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

Date (MM/DD/YYYY)

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

Signature of Additional Applicant/Insured/Claimant or Legal Representative

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

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





MIB Pre-Notice

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

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

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

Insurance Information Practices

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

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

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

Fair Credit Reporting Act

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

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

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

Telephone Interview Information

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



Conditional Receipt

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

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

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

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

Conditional Receipt

Assurity Life Insurance Company • Lincoln, Nebraska

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

1. The sum of \$_____ is received of _____ by Assurity Life Insurance Company ("The Company") as payment of the full initial premium on insurance applied for on this date. Payment is accepted subject to the terms and limitations of this Conditional Receipt ("Receipt"). It is expressly understood and agreed that unless all conditions set forth in this Receipt are satisfied, or that unless the coverage applied for is issued within 60 days of the date of application, no insurance shall ever take effect. In such case, the Company's only liability and obligation is to promptly refund the premium payment received.
2. If, on the applicable date, the Proposed Insured was acceptable for the plan and amount of insurance applied for, without modification, under Assurity's rules, limits and standards of insurability, coverage will be effective the later of i) the date of application, or ii) the date any medical examination of the Proposed Insured is completed, if required by the Company. Insurance will be issued at Assurity's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.
- 3a. Assurity Life Insurance Company has NO liability for life insurance coverage if the answers to the health questions on the application indicate any significant health problems. Otherwise, the Company's total life insurance liability, including the present value of future benefits for any reversionary annuity policy, for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company, including the present value of future benefits for any reversionary annuity policy, on the Proposed Insured's behalf (including that for which this Receipt is given) shall not exceed \$500,000 if all application health questions are answered, and shall not exceed \$100,000 if no application health questions are answered.
- b. Assurity Life Insurance Company has NO liability for health insurance coverage and this Receipt is void for any insurance if any health questions on the application have not been answered and no medical examination is required of the Proposed Insured. Otherwise, the Company's total health insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that which this Receipt is given) shall not exceed \$2,500 per month.

These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.
4. This Receipt must not be detached and used unless the full amount of the first premium is paid on the date of the application. Payment cannot be accepted with the application if any person proposed for coverage has been treated for or had any known heart trouble, stroke or cancer within the past twelve months. This Receipt is void if exchanged for any check or draft that is not honored upon first presentation for collection through usual banking facilities.

Dated: _____

Agent: _____



**BLOOD TESTING WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE**

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

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

The consent you give by signing this form authorizes the Insurer to withdraw blood and order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (*HIV*), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULTS

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

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

CONFIDENTIALITY OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (*MIB, Inc.*), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a nonspecific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or authorized by you.

COST OF TESTING

The cost of any testing will be borne by the Insurer.

NOTIFICATION OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact your designated physician, or you if you have not designated a physician, the Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.



TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

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

In the event of a positive HIV test result, I authorize Assurity Life to send the test results to the following health care professional:

Physician's Name _____

Physician's Address _____

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

Proposed Insured (Printed) _____
Date of Birth (MM/DD/YYYY)

Signature of Proposed Insured or Parent/Guardian _____
Date (MM/DD/YYYY) _____
State of Residence



COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Assurity Life Insurance Company. Therefore, Assurity Life makes no representations or warranties that this information is accurate as of the date you receive this list. Also, Assurity Life makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department or your local chapter of the American Red Cross for further information.

AIDS HOTLINE-U.S. PUBLIC HEALTH SERVICE
800-342-AIDS

SPANISH AIDS HOTLINE
808-344-7432

TTY INFORMATION
Information and Referral for Hearing Impaired
213-464-0029

SANTA CLARA COUNTY ARIS PROJECT
Campbell
408-370-3272

AIDS HOTLINE-SOUTHERN CALIFORNIA
800-922-AIDS

SONOMA COUNTY AIDS INFORMATION HOTLINE
707-579-AIDS

KERN COUNTY AIDS TEAM
Bakersfield
805-861-3631

AIDS PROJECT-EAST BAY
Oakland
415-420-8181

SACRAMENTO AIDS FOUNDATION
Sacramento
916-448-2437

CENTRAL VALLEY AIDS TEAM
Fresno
209-264-2436

SAN FRANCISCO AIDS FOUNDATION
San Francisco
415-846-5855

AIDS SERVICES FOUNDATION OF ORANGE COUNTY
Costa Mesa
714-646-0411

AIDS PROJECT-LOS ANGELES
West Hollywood
213-876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
714-784-2437

SAN DIEGO AIDS PROJECT
619-543-0300—City of San Diego
619-945-6000—City of Vista

SANTA BARBARA COUNTY AIDS HOTLINE
805-965-2925

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
Statewide Services
Office of AIDS-Sacramento
916-323-7415

HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA
Social Services-Southern California
Hemophilia AIDS Information
818-792-6192
714-740-2222

SHASTA COUNTY HELPLINE
916-225-5252





REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

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

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

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

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

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

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

INFORMATION ON POLICIES WHICH MAY BE REPLACED

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

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





REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

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

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

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

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

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

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

INFORMATION ON POLICIES WHICH MAY BE REPLACED

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

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



ILLUSTRATION DISCLOSURE STATEMENT

Proposed Insured's Knowledge and Agent's Certification of

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

PROPOSED INSURED ACKNOWLEDGEMENT

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

Proposed Insured's Signature

Date

AGENT CERTIFICATION

I certify that:

- An illustration matching the application for insurance was not provided at time of sale for the reason marked above (if a computer screen application was used, it was based on the following:
 - Gender Age
 - Underwriting Class
 - Policy Type
 - Initial Death Benefit
 - Riders
 - Assumed Interest Rate
- I explained that a conforming illustration would be produced and delivered no later than at the time of policy delivery.
- I explained that any non-guaranteed elements for the policy are subject to change.
- I have made no statements that are inconsistent with the illustration that will be produced.

Agent Signature

Date



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

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

1. Source of Funds

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

2. Intended purpose of applied for coverage

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

3. Applicant's background

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

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

5. Source of information

Name _____

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

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

 Producer Signature

 Producer No.

 Producer Name

 Date (MM/DD/YYYY)

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



