



1. PROPOSED INSURED

First Middle Last			(MM/DD/YYYY)	
Legal Name			Date of Birth / /	
Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female	E-Mail		Age
Street Address		City	State	ZIP+4
Home Address				
Personal Phone No. ()	Birth State/ Country	Driver's Lic. No./State	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(s):				Last date of use / / (MM/DD/YYYY)

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

First Middle Last			(MM/DD/YYYY)	
Legal Name			Date of Birth / /	
Social Security No.	Relationship to Insured		Birth State/Country	
Street Address		City	State	ZIP+4
Home Address				E-Mail

3. BENEFICIARIES (If multiple Beneficiaries, please attach additional sheets)

Primary Beneficiary Name (First, Middle, Last)	Relationship to Insured	Social Security No.	Date of Birth (MM/DD/YYYY)
			/ /
Contingent Beneficiary Name (First, Middle, Last)	Relationship to Insured	Social Security No.	Date of Birth (MM/DD/YYYY)
			/ /

4. HEALTH SECTION

Section A— If any question is answered YES, coverage cannot be issued.

- Has the Proposed Insured been medically diagnosed as having a life expectancy of **12 months** or less?..... Yes No
- In the past **12 months** has the Proposed Insured been diagnosed as having or been treated for uncontrolled diabetes or any complications thereof, including numbness, amputation, eye or kidney disorder, coma or insulin shock; or needed assistance or personal supervision to perform any activities of daily living (*toileting, transferring, continence, eating, bathing or dressing*); or had or been advised to have brain, heart or circulatory surgery, kidney dialysis or amputation caused by disease; or been confined to a nursing facility or received inpatient services at a medical facility 2 or more times? Yes No
- Has the Proposed Insured **ever** been diagnosed as having or been treated for (*including office visits, medication or surgery*): leukemia, systemic lupus erythematosus (*SLE*) or amyotrophic lateral sclerosis (*ALS*), cirrhosis, hepatitis type C, liver disease, kidney disease affecting both kidneys, dialysis, Alzheimer's disease, dementia, lymphoma or malignant melanoma; or received or been advised to receive an organ or tissue transplant; or in the past **2 years** been diagnosed as having internal cancer?..... Yes No
- Prior to age 25, has the Proposed Insured been diagnosed as having or received treatment for cerebral palsy, muscular dystrophy, cystic fibrosis, sickle cell anemia, Down's syndrome or congenital heart disease?..... Yes No
- Has the Proposed Insured had a test to detect the presence of cancer and not yet received the results, or been advised to have surgery for a heart condition or blood vessel disease, or been advised to receive medical treatment or tests that have not been completed (*not including HIV tests*)? Yes No
- Has the Proposed Insured **ever** been medically diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*) or AIDS-related complex (*ARC*)? Yes No

Section B— If this question is answered YES, the Proposed Insured will be considered for the Modified Benefit Whole Life coverage only.

- In the past **90 days** has the Proposed Insured been, or are they now, confined to a psychiatric facility or receiving home health care?..... Yes No

Section C— Complete only if all answers in Sections A and B were NO. Any YES answers in Section C limit consideration to Graded Benefit Whole Life.

- In the past **12 months**, has the Proposed Insured been medically diagnosed as having or been treated for: emphysema (*chronic obstructive pulmonary disease*), congestive heart failure or cardiomyopathy, cerebral vascular accident, stroke or aneurysm, any mental or nervous disorder requiring hospitalization, or had or been advised to have treatment for any drug or alcohol abuse? Yes No
- In the past **5 years**, has the Proposed Insured had heart disease requiring bypass surgery, angioplasty or placement of vascular stents? Yes No
- Has the Proposed Insured **ever** been diagnosed as having or been treated for (*including office visits, medication or surgery*): diabetes requiring insulin injections combined with a medical history of stroke, transient ischemic attack (*TIA*) or heart disease?..... Yes No

If all questions in Sections A, B and C are answered NO, the Proposed Insured will be considered for Level Benefit Whole Life coverage.

5. POLICY INFORMATION

Plan of Insurance: Level Benefit Whole Life Graded Benefit Whole Life Modified Benefit Whole Life Initial Death Benefit \$ _____

Premium Payment Mode: Annual Semi-Annual Quarterly Monthly (Automatic Bank Withdrawal) Monthly (Credit Card)

Is the insurance applied for intended to replace any insurance or annuity now in force? If YES, please provide details below. Yes No

Name of the company _____ Policy No. _____

AGREEMENT— No agent is authorized to change or waive the terms of this Agreement.

I, the Proposed Insured, agree that to the best of my knowledge and belief:

- 1. All answers in this Application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability.
2. The first premium is equal to the full premium for the Premium Payment Mode selected in Section 5, "Policy Information," above.
3. If the first premium is not paid on the date this Application is signed, no insurance will be in effect unless: a. A policy is delivered to and accepted by the Owner and the entire first premium is paid during my lifetime, and b. At the time of such delivery, acceptance or payment, whichever is later, all information furnished in this Application remains true and complete to the best of my knowledge.

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 subject to a substantial civil penalty where and to the extent allowed by state law.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or the Medical Information Bureau, Inc., that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy.

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

Signature of Proposed Insured

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

AUTOMATIC BANK WITHDRAWAL

Type of Account: Checking Savings Applicants and/or policy numbers to be included: _____

NEW sign authorization below, attach voided check. Date of Withdrawal _____ / _____ / _____ Add to existing bank withdrawal on _____ / _____ / _____
Date of Withdrawal cannot be the 29th, 30th or 31st. If no date is entered, the policy issue date will be used.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This authorization shall remain in effect until revoked by me in the manner provided by law. When I receive notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account. I request the first premium be debited from my account upon policy issue: Yes No

Name of Financial Institution

Routing No. (9-digit number)

Account No.

DO NOT SIGN

Signature of Account Holder

Date (MM/DD/YYYY)

Telephone No.

FIELD UNDERWRITER'S STATEMENT

I HAVE TRULY AND ACCURATELY RECORDED in this Application the information provided by the Proposed Insured and witnessed his or her signature.

Premium of \$ _____ was collected with this application.

To the best of my knowledge, if this insurance is issued, will it replace, modify or borrow against existing or pending coverage? Yes No

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

Signature of Soliciting Agent

Date (MM/DD/YYYY)

Business Phone No. and Fax No.

Soliciting Agent's Printed Name

Agent No.

Agent's E-mail

Signature of Soliciting Agent

Date (MM/DD/YYYY)

Agent No.

Business Phone No.

HOME OFFICE CORRECTIONS AND ADDITIONS ONLY





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.



LEVEL BENEFIT WHOLE LIFE														
Issue Age	MALE		FEMALE		Issue Age	MALE		FEMALE		Issue Age	MALE		FEMALE	
	NTob	Tob	NTob	Tob		NTob	Tob	NTob	Tob		NTob	Tob	NTob	Tob
0	6.95		5.44		27	14.96	16.53	13.65	15.20	54	35.06	42.69	29.88	37.53
1	7.22		5.72		28	15.11	17.04	13.76	15.61	55	36.46	44.56	30.88	38.83
2	7.55		6.03		29	15.30	17.56	13.92	16.04	56	37.91	46.57	31.92	40.17
3	7.90		6.35		30	15.56	18.08	14.13	16.47	57	39.39	48.69	32.99	41.53
4	8.29		6.68		31	15.90	18.59	14.41	16.90	58	40.98	50.99	34.14	42.98
5	8.69		7.03		32	16.30	19.10	14.75	17.34	59	42.77	53.57	35.45	44.59
6	9.11		7.39		33	16.74	19.63	15.12	17.81	60	44.83	56.49	36.98	46.45
7	9.54		7.77		34	17.22	20.20	15.53	18.31	61	47.13	59.71	38.75	48.56
8	10.00		8.15		35	17.73	20.82	15.96	18.86	62	49.61	63.17	40.71	50.89
9	10.47		8.55		36	18.25	21.49	16.40	19.44	63	52.33	66.96	42.84	53.40
10	10.95		8.96		37	18.80	22.19	16.84	20.05	64	55.35	71.16	45.12	56.05
11	11.46		9.25		38	19.38	22.95	17.33	20.71	65	58.72	75.84	47.53	58.82
12	11.98		9.50		39	20.02	23.76	17.87	21.44	66	62.42	80.94	49.97	61.63
13	12.48		9.73		40	20.73	24.66	18.48	22.26	67	66.41	86.40	52.46	64.49
14	12.67		9.96		41	21.53	25.65	19.20	23.20	68	70.73	92.33	55.14	67.53
15	12.85	14.38	10.19	13.24	42	22.41	26.72	20.00	24.26	69	75.42	98.84	58.14	70.87
16	13.03	14.51	10.42	13.37	43	23.33	27.86	20.85	25.37	70	80.51	106.04	61.60	74.63
17	13.21	14.64	10.65	13.51	44	24.29	29.03	21.71	26.50	71	85.65	113.52	65.37	78.50
18	13.40	14.77	10.87	13.64	45	25.25	30.22	22.54	27.60	72	90.83	121.20	69.35	82.40
19	13.58	14.90	11.12	13.77	46	26.20	31.42	23.32	28.66	73	96.55	129.71	73.78	86.80
20	13.76	15.03	11.42	13.90	47	27.16	32.63	24.09	29.71	74	103.36	139.66	78.88	92.17
21	13.94	15.15	12.01	14.01	48	28.14	33.89	24.86	30.76	75	111.76	151.67	84.88	98.99
22	14.12	15.28	12.63	14.10	49	29.16	35.20	25.65	31.83	76	121.70	165.61	91.75	107.27
23	14.30	15.41	13.14	14.20	50	30.25	36.59	26.46	32.93	77	132.84	181.07	99.35	116.68
24	14.48	15.54	13.28	14.34	51	31.38	38.02	27.29	34.05	78	145.25	198.24	107.70	127.23
25	14.66	15.67	13.42	14.55	52	32.54	39.47	28.11	35.17	79	159.04	217.34	116.88	138.90
26	14.82	16.07	13.54	14.85	53	33.76	41.01	28.97	36.32	80	174.28	238.57	126.92	151.69

GRADED BENEFIT and MODIFIED BENEFIT WHOLE LIFE									
Issue Age	MALE		FEMALE		Issue Age	MALE		FEMALE	
	NTob	Tob	NTob	Tob		NTob	Tob	NTob	Tob
40	31.31	39.02	28.13	35.07	61	70.77	97.10	57.94	77.68
41	32.60	40.74	29.37	36.88	62	74.14	102.49	60.30	80.70
42	33.92	42.53	30.61	38.68	63	77.82	108.36	62.87	84.00
43	35.27	44.37	31.84	40.49	64	81.95	114.82	65.69	87.70
44	36.66	46.27	33.06	42.29	65	86.65	121.95	68.84	91.95
45	38.08	48.23	34.27	44.10	66	91.81	129.50	72.17	96.71
46	39.51	50.21	35.46	45.89	67	97.35	137.41	75.64	101.89
47	40.95	52.22	36.61	47.65	68	103.43	146.06	79.47	107.54
48	42.43	54.31	37.77	49.43	69	110.20	155.84	83.86	113.69
49	44.00	56.52	38.96	51.25	70	117.82	167.15	89.04	120.40
50	45.68	58.93	40.20	53.14	71	125.89	179.54	94.73	127.22
51	47.49	61.52	41.48	55.12	72	134.29	192.76	100.79	134.13
52	49.39	64.25	42.77	57.16	73	143.65	207.46	107.62	141.77
53	51.38	67.13	44.11	59.25	74	154.54	224.31	115.64	150.81
54	53.46	70.18	45.51	61.37	75	167.58	243.97	125.25	161.91
55	55.62	73.41	47.01	63.53	76	182.62	266.18	136.37	175.04
56	57.77	76.70	48.56	65.64	77	199.28	290.48	148.73	189.77
57	59.93	80.04	50.14	67.70	78	217.74	317.29	162.44	206.12
58	62.21	83.61	51.82	69.83	79	238.21	347.01	177.65	224.13
59	64.73	87.57	53.66	72.16	80	260.90	380.02	194.47	243.80
60	67.61	92.09	55.71	74.81					

SAMPLE PREMIUM CALCULATION	
Annual Premium per \$1,000	= 58.72
Annual Premium = \$58.72 x 10 (# of \$1000s)	= \$587.20
+ Policy Fee	= \$25.00
Total Annual Premium	= \$612.20
Semi-annual Premium \$612.20 x .51	= \$312.22
Quarterly Premium: \$612.20 x .264	= \$161.62
Monthly Bank Draft: \$612.20 x .088	= \$53.87

All rates in U.S. Dollars.

Annual Premiums per \$1,000 of Face Amount.

Policy Fee: \$25.00



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.





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





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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





California Elder Notice to All Purchasers of Life Insurance or Annuities Age 65 or Over

You should be aware that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this life or annuity product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale or sold.

I have read the above notice and have received a copy.

Signature and Printed Name of Prospective Purchaser

Date (MM/DD/YYYY)

Signature and Printed Name of Prospective Purchaser's Spouse or Joint Owner

Date (MM/DD/YYYY)

Signature and Printed Name of Prospective Purchaser's Representative

Date (MM/DD/YYYY)





IMPORTANT NOTICE:

This notice is being provided to you in accordance with California law.

1. During this visit or a follow-up visit, you will be given a sales presentation on the following (*indicate all that apply*):

Life insurance, including annuities

Other insurance products (*specify*): _____

2. You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

3. You have the right to end the meeting at any time.

4. You have the right to contact the Department of Insurance for information, or to file a complaint.

You may contact the California Department of Insurance Consumer Hotline from 8:00 a.m. to 6:00 p.m., Monday through Friday, at 1-800-927-HELP (4357).

5. The following individuals will be coming to your home: (*List all attendees and insurance license information, if applicable.*)





NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

RECOVERY

An annuity purchased on or after Sept. 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after Sept. 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than the amount of an individual's resource allowance in countable resources (*\$2,000 for 2007*). The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance (*\$35 for 2007*) plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

- **Community Spouse Resource Allowance:** If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than the amount of community countable assets (*\$101,640 in 2007*).
- **Minimum Monthly Maintenance Needs Allowance:** If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or *\$2,541 (for 2007)*, whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than the amount of community spouse resource allowance (*\$101,640 for 2007*). The order also may allow the at-home spouse to retain more than *\$2,541 (for 2007)* in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

- **One principal residence:** One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home some day. The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it. Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- **Real property used in a business or trade:** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.



PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

- **IRA, KEOGH, or other work-related pension plans:** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity or otherwise change the form of the assets in order for them to be unavailable.
- **Personal property used in a trade or business.**
- **One motor vehicle.**
- **Irrevocable burial trusts or irrevocable prepaid burial contracts.**

THERE MAY BE OTHER ASSETS THAT ARE EXEMPT. This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

Purchaser's Signature and Printed Name

Date (MM/DD/YYYY)

Spouse's Signature and Printed Name

Date (MM/DD/YYYY)

Legal Representative's Signature and Printed Name

Date (MM/DD/YYYY)

