ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Application for INSURANCE

PLEASE PRINT WITH BLACK INK

1. PROPOSED INSURED

Legal Name *First* *Middle* *Last*			Date of Birth (MM/DD/YYYY) / /
Social Security No.	☐ Male ☐ Female	E-Mail	Age
Home Address *Street Address* *City* *State* *ZIP+4*			
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? ☐ Yes ☐ No

If YES, please list type(s): Last date of use / / *(MM/DD/YYYY)*

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

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

1. Has the Proposed Insured been medically diagnosed as having a life expectancy of **12 months** or less? ☐ Yes ☐ No
2. 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
3. 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
4. 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
5. 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? ☐ Yes ☐ No
6. Has the Proposed Insured **ever** been medically diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)*, AIDS-related complex *(ARC)* or antibodies to human T-lymphotropic virus type III *(HTLV)*, or had a positive test for human immunodeficiency virus *(HIV)* antibodies? ☐ Yes ☐ No
7. 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 B— Complete only if all answers in Section A were NO. Any YES answers in Section B limit consideration to Graded Benefit Whole Life.

1. 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
2. In the past **5 years**, has the Proposed Insured had heart disease requiring bypass surgery, angioplasty or placement of vascular stents? ☐ Yes ☐ No
3. 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 and B 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 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. If the first premium is paid on the date this Application is signed, the insurance applied for becomes effective on that date subject to: **a.** The Company's underwriting requirements, **b.** The terms of the attached Conditional Receipt, and **c.** The terms of the policy applied for, including its suicide and contestability provisions.
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. A photographic copy of this authorization shall be as valid as the original. **I agree** this authorization shall be valid for two years from the date shown below. **I understand** that I or my authorized representative may receive a copy of this authorization.

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

THIS PORTION HAS BEEN REPLACED WITH FORM 75-050-05055

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

☐ NEW—sign authorization below, attach voided check. Date of Withdrawal ___/___/___ *(MM/DD/YYYY)* ☐ Add to existing bank withdrawal on ___/___/___ *(MM/DD/YYYY)*

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. Until it receives 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

ASSURITY® LIFE INSURANCE COMPANY
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Customer Identification INFORMATION

PLEASE PRINT WITH BLACK INK

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 ______________
- ☐ How known ______________
- ☐ Applicant's occupation ______________

Business relationship with applicant? ☐ Yes ☐ No If so, describe ______________

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

	MALE		FEMALE			MALE		FEMALE			MALE		FEMALE	
Issue Age	NTob	Tob	NTob	Tob	Issue Age	NTob	Tob	NTob	Tob	Issue Age	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 WHOLE LIFE

	MALE		FEMALE			MALE		FEMALE	
Issue Age	NTob	Tob	NTob	Tob	Issue Age	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

YOUR PREMIUM CALCULATION	
Annual Premium per $1,000	
Annual Premium = (Amount x the # of $1000s)	
+ Policy Fee	= $25.00
Total Annual Premium	
Semi-annual Premium	
Quarterly Premium:	
Monthly Bank Draft:	

All rates in U.S. Dollars.

Annual Premiums per $1,000 of Face Amount.

Policy Fee: $25.00

AR, MA, MN, MO, NV

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CONSUMER INFORMATION

Conditional Receipt

Please make **all** premium checks payable to "Assurity Life Insurance Company." Please **do not** make checks payable to the agent or leave "payee" blank.

Received from ______________________________ with the attached Application to the Company the sum of $____________ as payment of the first premium for the life insurance applied for.

a. If the first premium acknowledged by this Conditional Receipt is paid on or before the date the Application was signed; and

b. If, on the date the Application was signed, the Proposed Insured was insurable without special exception and at standard rates under the Company's underwriting rules and practices for the insurance applied for;

c. The Company agrees to insure the Proposed Insured under this Conditional Receipt. The amount of insurance hereunder will be the lesser of the amount applied for, or the amount for which the Proposed Insured qualifies, but not to exceed $25,000 for any individual applying for insurance with the Company.

This Conditional Receipt terminates the earlier of a) 60 days after the date the Application was signed, or b) the date the insurance applied for becomes effective. If one or more of the conditions are not met, the Company's liability will be limited to the return of the sum received. This Conditional Receipt is controlled by the terms of the policy applied for. No agent is authorized to change or alter this Conditional Receipt.

_____________________	_____________________	_____________
Agent's Signature	*Agent's Printed Name*	*Date (MM/DD/YYYY)*

THIS PORTION HAS BEEN REPLACED WITH FORM 75-652-05055

Notice of Investigative Consumer Report

Required by the Fair Credit Reporting Act

We appreciate your application for insurance and intend to process it as speedily as possible so that you can know whether it has been approved. As is customary in the business world, and as part of our normal underwriting procedure, an investigative consumer report may be obtained. These reports typically include information on a Proposed Insured's character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates. Upon written request to the Underwriting Department at the Company's address above, further information as to the nature and scope of the report will be furnished you.

Notice of Acquisition & Disclosure of Confidential Information

Required by the Medical Information Bureau *(MIB)*

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

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number 617-426-3660.

Assurity Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Proposed Insured should retain this page in all instances.

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CONSUMER NOTICE

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.

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Life Insurance
REPLACEMENT NOTICE

IMPORTANT NOTICE REGARDING THE REPLACEMENT OF YOUR POLICY OF LIFE INSURANCE

You have been offered a policy to replace all or part of your existing policy of life insurance.

Before you replace your existing policy you should consider whether you could suffer a **FINANCIAL LOSS** under the new policy because of your **AGE** or the condition of your **HEALTH**. You should also consider whether you will pay more for premiums because of your age or health.

You **WILL** incur additional costs to acquire the new policy, including the payment of commissions to the agent advocating the replacement of your existing policy.

To make an informed decision about the replacement of your policy, you should discuss the provisions of your existing policy with your agent or the company which issued it to determine whether your policy can be changed to meet your present needs.

Your new policy provides ten *(10)* days for you to decide whether you wish to keep it.

The agent who is offering to replace your existing policy is required to obtain your signature on this notice. Also, we will be notifying your existing insurance company that you are considering the replacement of your policy.

I have read this notice and received a copy of it for my records.

______________________________ *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

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.

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I have read this notice and received a copy of it for my records.

______________________________ *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

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

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Automatic PREMIUM PAYMENT

Name of Proposed Insured ____________________ Date Signed ___/___/___
First *Middle* *Last* *(MM/DD/YYYY)*

Policy No. *(if for an existing policy)* ____________________

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

Name of Account Holder or Authorized Officer ____________________

☐ Initial and recurring premiums ☐ Recurring premiums only

If "Initial and recurring premiums" is marked, the company's authority to debit from your account the first premium for this insurance does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Type of Account: ☐ Checking ☐ Savings

Date of Withdrawal _________ Date ***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 listed below for premiums as selected above. I understand that initiating automatic payments may result in additional drafts to bring my account current. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account. I further understand that if the date of the withdrawal is after the policy issue date and if any premium is not honored, my policy may lapse and require evidence of insurability, according to the terms of my policy.

____________________ ____________________ ____________________
Name of Financial Institution *Routing No. (9-digit number)* *Account No.*

____________________ ___/___/___ (___)________
Signature of Account Holder or Authorized Officer and Title *Date (MM/DD/YYYY)* *Telephone No.*

TO ENSURE CODING ACCURACY, SUBMIT VOIDED CHECK
(unless application is submitted electronically)

CREDIT CARD AUTHORIZATION

Name of Account Holder or Authorized Officer ____________________

☐ Initial premium only ☐ Recurring premiums only ☐ Initial and recurring premiums

If "Initial premium only" or "Initial and recurring premiums" is marked, the company's authority to charge the first premium for this insurance to your credit card does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Type of Card: ☐ MasterCard ☐ Visa ☐ Discover

Date of Charge: ☐ 1st ☐ 5th ☐ 10th ☐ 15th ☐ 20th ☐ 25th
If no date is selected, recurring charges will occur on the option date immediately prior to the policy issue date.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate charges to my credit card listed below for premiums as selected above. I understand that initiating automatic payments may result in additional drafts to bring my account current. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any charges to my credit card. I further understand that if the date of the withdrawal is after the policy issue date and if any premium is not honored, my policy may lapse and require evidence of insurability, according to the terms of my policy.

____________________ ____________________ ___/___
Name as it appears on Card (Please print) *Card/Account No.* *Expiration Date (MM/YYYY)*

Credit card billing address ____________________
Street Address *P.O. Box* *City* *State* *Zip+4*

____________________ ___/___/___ (___)________
Signature of Account Holder or Authorized Officer and Title *Date (MM/DD/YYYY)* *Telephone No.*