



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

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? Yes No
- 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
- 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
- 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

5. POLICY INFORMATION

Plan of Insurance: Level 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.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fine and denial of insurance benefits.

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: _____
(MM/DD/YYYY) (MM/DD/YYYY)

New signature verification below, attach voided check. Date of Withdrawal _____ / _____ / _____
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. If 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

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

NC, WA, WV



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.





IMPORTANT NOTICE REGARDING REPLACEMENT OF INSURANCE

(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one — or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

STATEMENT TO APPLICANT BY AGENT OR BROKER:

(Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years? No Yes If "Yes," explain:

2. Are there penalties, setup or surrender charges for the new policy? No Yes If "Yes," explain, emphasizing any extra cost for early withdrawal:

3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?
 No Yes If "Yes," explain:

4. Are there adverse tax consequences from the replacement under current tax law? No Yes If "Yes," explain:

5. a) Are interest earnings a consideration in this replacement? No Yes

b) If "Yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings and the reduction of earnings that may result from setup charges, policy fees and other factors:

6. Are minimum amounts required to be on deposit before excess interest will be paid? No Yes If "Yes," explain:



7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
- a) Are the interest rates quoted before or after fees and mortality charges have been deducted?
 - b) Interest rates are guaranteed for how long? _____
 - c) The minimum interest rate to be paid is how much? _____
 - d) If applicable, the rate you pay to borrow is _____, and the limit on the amount that can be borrowed is _____.
 - e) The surrender charges are _____.
 - f) The death benefit is _____.

8. Are there other short or long-term effects from the replacement that might be materially adverse?

No Yes If "Yes," explain:

Signature of Agent or Broker

Date (MM/DD/YYYY)

Name of Agent or Broker (print or type)

Address

LIST OF POLICIES OR CONTRACTS TO BE REPLACED

Company	Insured	Policy or Contract Number
_____	_____	_____
_____	_____	_____

CAUTION: The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing agent or company. Such advice might be helpful.
- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: _____

Applicant's signature

Date (MM/DD/YYYY)

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.

To be completed if replacing another 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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_____	_____	_____

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- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

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