



Ohio Application for Simplified Critical Illness Insurance

This application includes all forms needed to apply for Simplified Critical Illness Insurance.

Thank you for your interest in writing business with Assurity Life Insurance Company.

To enable us to process your application more quickly, please review the following checklist:

- ✓ For Critical Illness products, the application should coincide with the **state in which the policy Owner resides** for the states listed below.

Simplified Critical Illness (Form CI 005): AR, CO, FL, ID, ME, MN, MT, NH, NC, ND, OK, PA, UT, WV
Critical Illness (Form CI 007): AR, ID, ME, MT, NC, ND, OK, PA, UT, WV

All other applications should coincide with the **state where the application is signed**. State specific applications and state forms can be found on the Extranet.

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state coinciding with the application used**.
- ✓ Print the application in black ink for faxing and photocopying purposes.
- ✓ Please verify that all questions on the application are answered. Obtain all required signatures.
- ✓ Have the Proposed Insured initial any changes. (Corrections with white correction fluid/tape are not acceptable.)
- ✓ Comply with all state regulations
 1. Complete all other pertinent and applicable forms padded together in this application.
- ✓ If the Proposed Insured has a history of heart trouble, stroke, or cancer, do not collect the initial premium.
- ✓ If faxing an application directly to the Home Office, fax to (402) 437-4591.
If emailing an application directly to the Home Office, email to appssubmit@assurity.com.
- ✓ If mailing directly to the Home Office, address to: **Assurity Life Insurance Company**
Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

TO CHECK THE STATUS OF AN APPLICATION, ASK QUESTIONS RELATING TO UNDERWRITING (INCLUDING "WHAT IF" SCENARIOS) CALL TOLL FREE 800-276-7619, EXT. 4264 OR EMAIL TO underwriting@assurity.com.

Assurity Life Insurance Company

Application for Critical Illness Insurance

I hereby apply for insurance with Assurity Life Insurance Company.

A. Proposed Insured

1. Name _____		2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. a. Date of Birth b. Birth State _____	4. Age _____				
5. Address _____			6. Social Security Number _____					
7. City, State, ZIP _____			8. Telephone (Area Code/Number) _____					
9. Height _____	10. Weight _____	11. Best Time to Call _____						
12. U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, how long has he or she been in the U.S.? _____ If not a citizen, does he or she have a permanent visa? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide a copy.								
13. Employer _____ Occupation _____ Duties _____								
14. Plan: <u>Critical Illness</u>		Benefit Amount: \$ _____	15. Rider(s)					
Premium Payment Method:		Amount Collected: \$ _____	<input type="checkbox"/> Accidental Death Benefit \$ _____ <input type="checkbox"/> Children's Rider <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Return of Premium <input type="checkbox"/> Spouse Rider Benefit Amount \$ _____ <input type="checkbox"/> Waiver of Premium					
<input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____								
16. Name of spouse and/or dependent children (who have not reached their 19 th birthday) proposed for coverage under the Spouse and/or Children's Rider.								
Full Name	Relationship	Sex M/F	Date of Birth	Age	Height	Weight	Residing with Proposed Insured	
_____	Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	_____	Yes	No
_____	Child	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	Child	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	Child	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
17. Beneficiary Name		Relationship		SS#/TIN		Date of Birth/Trust		
Primary: _____								
Contingent: _____								

B. Answer the Following Questions:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Does the Proposed Insured(s) have any other Critical Illness (lump sum diagnostic benefits) coverage in force and applied for? If Yes , list company name and amount. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 2. If under age 65, is the Proposed Insured(s) receiving Medicare or Medicaid? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes , name of person(s) _____ | | |
| 3. Has the Proposed Insured(s) been postponed or declined Critical Illness coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes , name of person(s) _____ | | |
| 4. Has there been, or will there be, a lapse, surrender, loan, or other change to any existing health insurance as a result of, or in anticipation of, this application?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Estimated Annual Income \$ _____ Sources: _____ | | |

C. Health History (Questions 1 through 6 apply to all Proposed Insured(s)):

- | | YES | NO |
|--|---|--------------------------|
| 1. During the past two years, has the Proposed Insured(s) received medical care from a member of the medical profession for, or experienced symptoms of, any of the following? If Yes, indicate all that apply..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Disorder of the heart or circulatory system
<input type="checkbox"/> Unexplained Weight Loss
<input type="checkbox"/> Fibrocystic breast disease, recurrent breast tumors, or unexplained tumors/growths | <input type="checkbox"/> Unexplained Fatigue
<input type="checkbox"/> Unexplained Dizziness
<input type="checkbox"/> Abnormal Pap Smear | |
| 2. Has the Proposed Insured(s) ever received medical care from a member of the medical profession for, or been diagnosed with, any of the following? If Yes, indicate all that apply..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Stroke (including Transient Ischemic Attack)
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Cancer (other than skin cancer)
<input type="checkbox"/> Melanoma
<input type="checkbox"/> Abnormal Kidney Functions
<input type="checkbox"/> Recurrent Human Papilloma virus (HPV) or Sexually Transmitted Disease (within the past 5 years)
<input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus infection (symptomatic or asymptomatic) or any AIDS related condition | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Hepatitis B or C
<input type="checkbox"/> Chronic Lung Disease
<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Skin Cancer (2 or more occurrences)
<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Alzheimer's or Senile Dementia
<input type="checkbox"/> Systolic Blood Pressure 150 or greater within the last 6 months
<input type="checkbox"/> Diastolic Blood Pressure 95 or greater within the last 6 months | |
| 3. Does the Proposed Insured(s) intend to live or travel outside the United States or Canada for more than two months during the next 24 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. During the past two years has the Proposed Insured(s) been advised by a member of the medical profession: | | |
| a) of any abnormal diagnostic test results or been advised to have any diagnostic tests (includes self-administered) which have not yet been completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) to undergo any treatment, hospitalization or surgery which has not yet been completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. During the past five years, has the Proposed Insured been unable to perform any of the following activities on his/her own: transferring in or out of a chair or bed, dressing, bathing, feeding, toileting or continence? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have any two or more of the Proposed Insured's natural parents, brothers or sisters, either living or deceased, been diagnosed with the same condition(s) from the following list: | | |
| • Heart disease, stroke, diabetes, kidney disease or breast cancer prior to age 60? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Colorectal cancer or Alzheimer's or Senile Dementia prior to age 75? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Any other same cancer in both relatives prior to age 55? | <input type="checkbox"/> | <input type="checkbox"/> |
| If any question in this section (Section C, Questions 1 – 5) is answered "Yes", list the name(s) of the person(s).
_____ | | |
| 7. Has the Proposed Insured(s) used any tobacco or nicotine product during the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes", list name(s): _____ | | |

Automatic Bank Withdrawal

Automatic Bank Withdrawal conveniently pays your monthly premium from your checking account – saving you time and money. To begin this convenient service, please complete the form below and return it to us with a voided check. Remember to indicate the date of withdrawal that would be most convenient for you.

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.

Date of Withdrawal: _____ (cannot be the 29th, 30th or 31st; IF NO DATE IS ENTERED, THE POLICY ISSUE DATE WILL BE USED.)

Draft initial premium payment: Yes No FIRST PREMIUM FOR THIS INSURANCE WILL BE DEBITED FROM YOUR ACCOUNT AT THE TIME THE POLICY IS ISSUED.

Signature of Account Holder

Telephone Number

Date Signed

Credit Card Authorization

I authorize Assurity Life Insurance Company to charge the credit card listed below in the amount of \$_____ for the first premium on the policy or policies for which I am applying on this date. I acknowledge 1) the use of the credit card for payments is optional; 2) this authorization does not cover the charging of future premiums; 3) coverage under the policy begins only as specified in the Conditional Receipt I have received; 4) my account will be credited if I make use of the Policy's Right to Cancel provision; and 5) this charge will be initiated only when the accompanying application is accepted.

Name on Card

Card/Account Number

Expiration Date

Date of Signature

Signature of Card Holder

Mastercard

Visa

Discover

CONDITIONAL RECEIPT

Assurity Life Insurance Company

1526 K Street, P.O. Box 82533
Lincoln, Nebraska 68501-2533
Toll Free 1-800-276-7619, Ext. 4264

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 Assurity Life Insurance Company the sum of \$ _____ as payment of the first premium for the life insurance and/or disability income insurance applied for

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

the Company agrees to insure the Proposed Insured(s) 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 \$50,000 for any individual applying for life insurance or \$1,500 of monthly benefit for any individual applying for disability income 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.

Date

Agent

ASSURITY LIFE INSURANCE COMPANY

1526 K STREET • PO BOX 82533 • LINCOLN, NEBRASKA 68501-2533 • TOLL FREE 800-276-7619, EXT. 4264

AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL INFORMATION

Name of Proposed Insured ("Applicant") _____

I, on behalf of myself (or the minor child named above), 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, clearing house, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company"), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from 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 applicants residing in Maine or Vermont. **For residents of Maine, this authorization excludes disclosure of the results of a test for HIV if the Applicant 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 applicant 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 Proposed Insured IS NOT authorizing the Company to forward the results from any new test requested by the Company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.**)
- Information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.
- Information provided on my application 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 the Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Proposed Insured 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 Proposed Insured do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, clearing house or other health care provider to release and disclose the Proposed Insured'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. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company, 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 or policy reinstatement, and 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 the Company. 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, the Company may not be able to process this application.

Signature of Proposed Insured or Authorized Representative Date

Description of Authorized Representative or Relationship to Proposed Insured

UNDERWRITING AUTHORIZATION AND ELECTION

Name of Proposed Insured ("Applicant") _____

I, on behalf of myself or the person named above ("Applicant"), 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 other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company") or Assurity's Parent Company, its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Psychotherapy notes.

I understand that this information may be released by the Company or Parent Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Applicant 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 Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire psychotherapy notes 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 when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company or Parent Company and may no longer be protected by the federal rules governing privacy of health information.

This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by providing written notice to the Company or Parent Company. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Applicant to obtain treatment. I further understand that if I refuse to sign this authorization, Company or Parent Company may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

I acknowledge receipt of Company's or Parent Company's Description of Information Practices which includes notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request and that a photographic copy of this authorization shall be as valid as the original.

I elect to be interviewed if an investigative consumer report is prepared in connection with my application(s) for insurance.

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 the law.

Signature of Proposed Insured or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Insured _____

AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL INFORMATION

Name of Proposed Insured ("Applicant") _____

I, on behalf of myself (or the minor child named above), 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, clearing house, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company"), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from 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 applicants residing in Maine or Vermont. **For residents of Maine, this authorization excludes disclosure of the results of a test for HIV if the Applicant 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 applicant 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 Proposed Insured IS NOT authorizing the Company to forward the results from any new test requested by the Company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.**)
- Information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.
- Information provided on my application 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 the Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Proposed Insured 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 Proposed Insured do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, clearing house or other health care provider to release and disclose the Proposed Insured'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. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company, 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 or policy reinstatement, and 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 the Company. 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, the Company may not be able to process this application.

Signature of Proposed Insured or Authorized Representative Date

Description of Authorized Representative or Relationship to Proposed Insured

UNDERWRITING AUTHORIZATION AND ELECTION

Name of Proposed Insured ("Applicant") _____

I, on behalf of myself or the person named above ("Applicant"), 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 other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company") or Assurity's Parent Company, its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Psychotherapy notes.

I understand that this information may be released by the Company or Parent Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Applicant 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 Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire psychotherapy notes 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 when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company or Parent Company and may no longer be protected by the federal rules governing privacy of health information.

This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by providing written notice to the Company or Parent Company. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Applicant to obtain treatment. I further understand that if I refuse to sign this authorization, Company or Parent Company may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

I acknowledge receipt of Company's or Parent Company's Description of Information Practices which includes notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request and that a photographic copy of this authorization shall be as valid as the original.

I elect to be interviewed if an investigative consumer report is prepared in connection with my application(s) for insurance.

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 the law.

Signature of Proposed Insured or Personal Representative _____

Date _____

Description of Personal Representative's Authority or Relationship to Insured _____

DESCRIPTION OF INFORMATION PRACTICES
including the notices required by the
Fair Credit Reporting Act and the Medical Information Bureau, Inc.

This notice is a general description of the information practices followed by Assurity Life Insurance Company, ("Company"), Assurity's reinsurers, and by Your Assurity agent.

NOTICE OF INVESTIGATIVE CONSUMER REPORT – Required by the Fair Credit Reporting Act

In the course of properly underwriting and administering Your insurance coverage, We rely on the information You provide in Your application. We may also seek personal information about You from others, and/or obtain an investigative consumer report. This is customary in the business world, and part of the normal underwriting procedure. Investigative consumer reports typically include information about Your character, occupation, finances and mode of living, except as relates to sexual orientation. This information will be obtained through personal interviews with Your friends, neighbors and associates. You may write to Us and request further information about the nature and scope of the report. You may also elect to be interviewed in connection with the preparation of an investigative consumer report. You are entitled to request and receive a copy of any investigative consumer report.

NOTICE OF ACQUISITION AND DISCLOSURE OF CONFIDENTIAL INFORMATION – Required by the Medical Information Bureau (MIB)

Information regarding Your insurability will be treated as confidential. In some situations, and as allowed by law, We may disclose necessary items of information to third parties without Your specific authorization. We, as well as Our reinsurers, may make a brief report regarding Your insurability to Medical Information Bureau, Inc. ("MIB"). MIB is a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If You apply for life or health insurance coverage, or submit a claim for benefits to another MIB member company, that company may request and receive information in MIB's files.

You have a right to be told about, to see and to copy information about You contained in Our files. You also have the right to seek correction of information You believe to be inaccurate. MIB will also arrange disclosure of any information it may have in Your file upon receipt of Your request. If You question the accuracy of information in MIB's file, You may contact MIB at the address below and seek a correction according to the procedures set forth in the Fair Credit Reporting Act.

If You have questions after reading this notice, You may write to Us at the address below. We would be happy to provide a more detailed description of Our information practices. If You are already an Assurity Life Insurance Company policyholder or insured, Your individual policy number will help Us in assisting You.

Company's Address

Assurity Life Insurance Company
Underwriting Department
PO Box 82533
Lincoln, Nebraska 68501-2533
Toll-Free No. (800) 276-7619, Ext.4264

MIB'S Address

Medical Information Bureau, Inc
Information Office
PO Box 105, Essex Station
Boston, Massachusetts 02112
Telephone No. (617) 426-3660