

How can you get **FASTER ISSUE** on your Assurity applications for **fully underwritten Disability Income and Life insurance?**

Assurity Life Insurance Company is working with you to get your business underwritten and issued as fast as possible. This will put the policy in your client's hand and commissions in your pocket!

While underwriting, the mail, and physicians all have an effect on your business, here are some steps to help you speed up the process.



A Member of the
Lincoln Insurance Group
Toll Free: 1-800-276-7619
Intranet Address: <http://info.assurity.com>

Nebraska Application for Disability Insurance

This application includes all forms needed to apply for Disability Insurance.
This application does not include the Life section(s).

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

You may write a Life application in combination with this Disability application. Simply complete the appropriate Life section(s) along with this application. The Life section(s) can be obtained from the **Intranet** or from a Life application. The **advantages of writing a combined application** are:

- answer medical questions once
- reviewed by Underwriting once
- scheduling one medical exam
- achieve two sales with one visit.

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

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity in the policy Owner's* "State of Residence".
- ✓ Use the appropriate application for the state in which the policy Owner* resides. Applications and state forms may be found on our Intranet.

***On Disability applications, the Proposed Insured and the policy Owner must be the same person.**

- ✓ Print the application in black ink for faxing and photo copying purposes.
- ✓ Please verify that all questions on the application are answered.
- ✓ Use age nearest birthday when preparing illustrations and/or calculating insurance premiums.
- ✓ Obtain all required signatures.
- ✓ Have the Proposed Insured initial any changes. (Corrections with white correction fluid are not acceptable.)
- ✓ Review the Conditional Receipt for collection limits. (If Proposed Insured has a history of heart trouble, stroke, or cancer, do not collect the initial premium.)
- ✓ If faxing directly to the Home Office, fax to (402) 437-4591
- ✓ If mailing directly to the Home Office, address to: **Assurity Life Insurance Company**

Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

Be sure the correct state application is used, and remember to use "age nearest birthday"

Step 1 Write carefully

The applications are state specific and must match the resident state of the client. Any changes, additions, or deletions will require an Amendment of Application form to be signed at delivery. Underwriting cannot adjust information on the application. Any changes made during the application process must be initiated by the Applicant. The use of white correction fluid is not acceptable.

Insurance Application to Assurity Life Insurance Company

PART 1 – General Section

I hereby apply for insurance with Assurity Life Insurance Company to be issued in reliance upon the following statements which I represent to be complete and true to the best of my knowledge and belief:

1. A. Full First Name (Please Print) Middle Initial Last Name		B. Social Security # ____-____-____	C. Sex <input type="checkbox"/> M <input type="checkbox"/> F
D. Date of Birth Mo. Day Year / /	E. Age Nearest birthday	F. Height Weight	G. Weight change in past year _____ lbs. <input type="checkbox"/> loss <input type="checkbox"/> gain
2. A. Residence: Street and No.		City	State Zip Code
B. Proposed Insured's home phone number		Best time to call Proposed Insured	
3. A. Occupation and duties (including those pertaining to any part-time occupation)		B. Employer and address	D. Gross average Monthly income (if not self-employed)
		C. How long employed?	If self-employed, net monthly income:

Fill in all basic information on your client.

Q2b: Insert applicant's home phone number and the best time to call, include area code, to assist with the Inspection Report.

Include job **duties**, not just job **title**.

Q3d: Note the difference between self-employed and non-self-employed. include the income appropriate.

Make sure all questions are answered "yes" or "no"

Any undeclared use of tobacco in the last 12 mo. with a positive finding will result in a "tobacco" classification.

Make sure DL # is filled in for DMV background check.

4. Do you belong to any National Guard or military? Yes No
If "yes," please explain: _____
5. Has any person to be covered flown during the last 5 years as a pilot, student pilot or crewmember? Yes No
If "yes," please complete the Avocation Questionnaire.
6. Has any person to be covered participated during the last 3 years in any hazardous sports or activities such as motor vehicle or boat racing, sky diving, skin or scuba diving or any such related activities? Yes No
Are any such activities contemplated? Yes No
If "yes," please complete the Avocation Questionnaire.
7. Do you contemplate residence or travel outside of the United States for more than 60 days within the next year? Yes No
If "yes," please explain: _____
8. Within the last 5 years, have you or to your knowledge has any person to be covered:
 - A. Had life, health, or hospital expense insurance postponed, rated up, ridered, declined or had renewal or reinstatement refused? Yes No
 - B. Received benefit payments for accident or sickness or applied to any government or insurance organization for such benefits? Yes No
 If either A or B is answered "yes," please explain: _____
9. If this insurance is issued, will it replace any insurance, annuity or other policy? Yes No
If "yes," please complete: Policy Number: _____
Name and address of company being replaced _____
(Send the State replacement forms with application.)
10. Are you negotiating for other insurance coverage? Yes No
If "yes," please explain: _____
11. Has the Proposed Insured ever used any form of tobacco or nicotine-based products? Yes No
If "yes," when did the Proposed Insured last use tobacco or nicotine-based products? Date: _____
12. Driver's license number: _____
Has any person to be covered received any citations within the last 5 years for motor vehicle moving violations or had a driver's license suspended or revoked? Yes No
If "yes," please explain: _____

Step 2: Health Questions

Q 13: If the answer to the question is NONE, please place that in the Full Name box. **Do not leave the question blank.**

Q 14: Answer all health Questions "yes" or "no".

If there are any "yes" answers, be sure to fill in the boxes in # 16.

Fill in full name, address and phone of the physician.

"Immediate family" includes parents and siblings only.

Part 1 – General Section (Cont.) If medical exam required due to age and/or amount, you may omit answering questions 14-19 on Proposed Insured.

13. Names of dependent Children (who have not reached their 19th birthday) proposed for Children's Term Insurance Rider. **(Note: Please complete 14-17 for any children to be covered.)**

Full Name	Relationship	Birthdate	Age	Height	Weight lbs.	Residing with Proposed Insured? (Circle)		Name/Address of Personal Physician
						Yes	No	

14. Have any persons to be covered ever been treated for, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following? If "yes," circle condition(s) and complete #16 below.

- A. Dizziness, fainting spells, epilepsy, depression, anxiety, mental disorder, or any disease or disorder of the brain or nervous systems? Yes No
- B. Asthma, bronchitis, tuberculosis, pneumocystis, or any disorder of the lungs or respiratory system? Yes No
- C. High blood pressure, chest pain, shortness of breath, heart murmur, rheumatic fever or any disease or disorder of the heart, hemophilia or coagulation disorder? Yes No
- D. Any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder? Yes No
- E. Any disease or disorder of the kidney, bladder or prostate? Yes No
- F. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles? Yes No
- G. Diabetes, or sugar, albumin or blood in the urine? Yes No
- H. Cancer or a tumor or cyst of any kind, or enlargement of lymph nodes? Yes No
- I. Varicose veins, varicose ulcer or phlebitis, syphilis, or a hernia? Yes No
- J. Any disease or disorder of the eyes, ears, nose or throat? Yes No
- K. Any advice or treatment for alcoholism, drug addiction, drug abuse or other substance abuse? Yes No
- L. Have you ever received medical diagnosis of, or tested positive for AIDS (Acquired Immunological Deficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder? Yes No
- M. Any other illness or injury requiring blood transfusion or other medical attention? Yes No
- N. Any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests other than AIDS related blood tests, or urine tests during the past 5 years? Yes No

15. Answer only if applying for the Catastrophic rider on your Disability Income application.

Have you ever needed assistance or personal supervision to perform any Activities of Daily Living (toileting, transferring, continence, eating, bathing, or dressing)? If "yes", please explain below in question #16. Yes No

16. If any questions in 14 are answered "yes," indicate the question number and give complete details. **If additional space is required, attach a separate page signed by the Proposed Insured.**

No.	Name of Person	Condition	Onset Date	Duration	Names, Addresses and Phone #'s of all Physicians, Hospitals and Medical Facilities

17. Name, address, phone and fax # of Proposed Insured's regular physician:	Date last consulted:
	Reasons and results:

18. Family History: Has any of your immediate family members (parents, brothers, or sisters) died from cancer, diabetes or cardiovascular disease prior to age 60? Yes No

If "yes," identify family member, disorder, and age at death below:

19. A. Has any person to be insured had any disorder of any genital or reproductive organ; or a miscarriage, stillbirth or Cesarean section? Yes No

B. Is any person to be insured now pregnant? If "yes," give date child is expected: Yes No

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Step 3 – Disability Information

Q 20: If there is no other coverage, be sure to insert NONE.

List all coverage the Applicant currently has.

Q 21: Insert the type of policy you are applying for: PDI-Personal DI, BOE-Business Overhead Expense.

Monthly Income Base Amount refers to the amount of base benefit being APPLIED for.

Optional Benefits/Riders This is for the AMOUNT of SDIR being applied for and then select any riders requested by the applicant.

To be completed only if applying for BOE coverage.

PAC must be chosen for the Monthly premium mode.

City, state, and date

Agent signature

PART 1 – DISABILITY SECTION

20. If the Proposed Insured were to become disabled, what amount of income or benefits would be received from: **1)** Individual Disability Income Policy, **2)** Sick Pay Plan and Salary Continuation Plans, **3)** Group Long and Short Term Disability Coverage, **4)** Business Overhead Expense, and **5)** Credit Disability Insurance. If **"None,"** so state.

Company or Source	Type 1, 2, 3, 4 or 5 (above)	Monthly Amount	Elimination Period	Benefit Period

21. Disability Plan _____
 Monthly Income Base Amount _____ Occupation Class _____ Tobacco Non-Tobacco
 Elimination Period: 30 60 90 180 365 Days
 Benefit Period: 1 year 2 years 5 years To age 65

OPTIONAL BENEFITS/RIDERS

Supplemental Disability Income Rider \$ _____ Guaranteed Insurability _____ Units
 Hospital Benefit Non-cancellable 5-Year Own Occupation Automatic Increase
 Residual Benefit Return of Premium Other _____
 Catastrophic Disability (Select desired Benefit Period for Catastrophic Disability Rider)
 Available with 1 year Base Benefit Period: 4 Year Rider Benefit Period or 9 Year Rider Benefit Period
 Available with 2 year Base Benefit Period: 3 Year Rider Benefit Period or 8 Year Rider Benefit Period
 Available with 5 year Base Benefit Period: 5 Year Rider Benefit Period

22. Who should receive Survivor Benefits? Name _____ Relationship _____

BUSINESS OVERHEAD EXPENSE DISABILITY

23. Monthly Income Base Amount \$ _____ Occupation Class _____ Tobacco Non-Tobacco
 Elimination Period 30 60 90 Days Benefit Period 12 months 24 months

24. Average monthly expenses currently incurred, for which Proposed insured is liable.

Employee's Salaries	\$ _____	Business Insurance Premiums	\$ _____
Utilities (Electricity, Gas, Water, Telephone)	\$ _____	Accounting Fees	\$ _____
Business Space (Rent or Mortgage Payment)	\$ _____	Property and Payroll Taxes	\$ _____
Furniture, Equipment Payments (Lease or Principal)	\$ _____	Other Eligible Expenses (please list)	\$ _____
Laundry, Office Maintenance	\$ _____		\$ _____

TOTAL MONTHLY EXPENSES \$ _____

25. How shall premiums be payable? Annually Semi-annually Quarterly PAC Other _____

I AGREE THAT

- A. I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree that this application (Part 1—General Section, pages 1 and 2 and Part 1—Disability Section, and Answers Made to the Medical Examiner if required) shall form a part of the policy if attached thereto.
- B. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Conditional Receipt delivered by the Company's agent in exchange for such payment.
- C. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless the application is approved by the Company at its Home Office, such policy issued and delivered to Proposed Insured/Owner, and such first full premium paid during the Proposed Insured's lifetime and continued good health, and when such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- D. No agent or medical examiner has power or is authorized to change or waive any term, provision or condition of this application, the Conditional Receipt, or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Signed at _____ this _____ day of _____, Year _____

Witnessed by _____ Licensed Resident Agent _____ Signature of Proposed Insured _____

Agency No _____

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Agent's code (4 digits)

Applicant signature

Step 4 Life Information

Remember, you can apply for Life and Disability policies without repeating Pages 1 and 2.

Please complete the Traditional Product Life Section / Flexible Premium Universal Life Section page for the type of Life product being applied for.

Q 21: If no in-force Life coverage exists, indicate "none".

Part 1 – Traditional Product Life Section/Flexible Premium Universal Life Section

21. What is the total amount of life insurance (personal and business) in force on your life? Include coverage under any term riders and accidental death benefits under accident insurance policies. If "None," so state.

Company	When Issued	Amount	ADB Amount

Traditional Product Life Section: (Complete this section if applying for Whole Life or Term products)

22. Plan of Insurance _____ Amount of Base Plan \$ _____ Number of years for term policies _____
 If cash value is available, should the Automatic Premium Loan Provision be made effective? Yes No
23. Additional Benefits (if available). **Check benefit(s) desired and indicate amount requested.**
 Waiver of Premium ART Rider \$ _____ Level Decreasing
 Accidental Death Benefit Children's Term Insurance Rider _____ units
 Protected Insurability Rider _____ units Decreasing Term Rider (Mortgage Protection) \$ _____
 VER Periodic \$ _____ premium Single \$ _____ premium 10 Yr. 15 Yr. 20 Yr. 25 Yr. 30 Yr.
24. Dividend Option: (If none chosen, policy provisions determine option.) _____
 Some options not available on all plans of insurance. **(Proceed to Question #29 if not applying for a Universal Life)**

Universal Product Life Section: (Complete this section if applying for Universal Life products only)

25. Plan of Insurance _____ Face Amount \$ _____
26. Planned Premium: (Amount to be billed or deposited each payment period) Amount \$ _____
27. Death Benefit Option: Option One: Face Amount Option Two: Face Amount Plus Cash Value
28. Additional Benefits (if available). **Check benefit(s) desired and indicate the amount requested.**
 Waiver of Monthly Deductions Children's Term Insurance Rider _____ units
 Accidental Death Benefit \$ _____ Amount YRT Rider (level only) \$ _____
 Protected Insurability Rider _____ units
29. How shall premiums be payable? Annually Semi-annually Quarterly PAC Other _____
30. Owner and relationship to Proposed Insured. (if no Owner is designated, the Proposed Insured shall be the Owner.)
 A. Owner's Name: _____ Relationship: _____
 B. Owner's mailing address: _____

 _____ Street and No. City State Zip Code
- C. If Owner other than Proposed Insured, Owner's Social Security # or Tax I.D. _____

Q 31: Indicate full name and relationship of all beneficiaries.

31. The Primary Beneficiary or Beneficiaries who survive the Proposed Insured by 120 hours shall share equally unless otherwise indicated.
 A. Primary Beneficiary and relationship to Proposed Insured _____
 If no Primary Beneficiary survives the Proposed Insured by 120 hours, benefits will be paid in equal shares to the Contingent Beneficiaries, if surviving the Proposed Insured by 120 hours, unless otherwise specified.
 B. Contingent Beneficiary and relationship to Proposed Insured _____

I (WE) AGREE THAT

- A. I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief. I (We) agree that this application (Part I – General Section, pages 1 and 2, Part II – Medical (if required), Traditional Product Life Section/ Flexible Premium Universal Life Section, and Avocation Questionnaire (if required)) shall form a part of the policy if attached thereto.
- B. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Conditional Receipt delivered by the Company's agent in exchange for such payment.
- C. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless the application is approved by the Company at its Home Office, such policy issued and delivered to the Proposed Insured/Owner, and such first full premium paid during the Proposed Insured's lifetime and continued good health and the lifetime and continued good health of any other person(s) covered under the policy, and when such approval, issue, delivery, and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- D. No agent or medical examiner has power or is authorized to change or waive any term, provision or condition of this application, the Conditional Receipt, or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

The app must be dated, witnessed by the writing agent, and signed by all legal aged applicants and any owners.

Signed at _____ this _____ day of _____, Year _____

Witnessed by _____ X _____
 Licensed Resident Agent Signature of Proposed Insured

Agency No. _____ X _____
 Signature of owner (if not Proposed Insured)

APP-01-LIFE (NE) Complete Form APP-01-APTR (NE) if applying for Additional Person Term Rider

Step 5 Field Underwriting

The Assurity Personal Disability Income product is intended to be sold face-to-face by a broker appointed with Assurity Life Insurance Company. Answer all questions completely.

Conditional Receipt LU-CR is found in this packet of forms and must be given to the proposed when full modal premium is collected.

Q 2A: Check yes or no. If No, explain in #7.

Q 2D: If the proposed insured is not a US citizen, please complete the question and include their visa number and expiration date.

Q 3: To be applied for as non-med, the applicant must have answered all medical questions in question 14 in the general section. Broker is to order the paramed. Enter name and address of paramed being used.

Write in broker name and 4 digit code #

A voided check must be used for PAC setup.

Check if new list bill. Send in all apps to be included in this list bill, together with a cover sheet listing all names of list bill applicants.

Field Underwriter's Statement

1. A. What amount was collected with this application? \$ _____
- B. Has a Conditional Receipt been given to the Proposed Insured/Owner? Yes No
- C. Has an Authorization for Release of Medical Information been signed and Fair Credit and M.I.B. notification been given? Yes No
2. A. Did you personally see all persons to be insured on date of application? Yes No
If "No," please explain in #7.
- B. How well do you know Proposed Insured? Well Slightly Relative Not at all
- C. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? Yes No
If "Yes," please explain in #7.
- D. Is the Proposed Insured a citizen of the United States? Yes No
If "No," provide type of visa, number, and expiration date below: _____
3. Is application being submitted on a non-medical basis? Yes No
If "No," check items for which arrangements have been made:
 Medical exam by physician with Home Office specimen Blood Profile EKG Chest X-ray
 Paramedical examination with Home Office specimen* Dried Blood Profile Blood Profile EKG
*Preferred Plus and Preferred underwriting classifications require blood profile, not dried blood spot.

Name and address of examiner _____
Date above items to be completed _____

4. All Life cases require a signed illustration be submitted with the application or a signed Illustration Disclosure Statement. The Premiums for this application were quoted on the following underwriting classification:
 Preferred Plus Preferred Select (standard, non-tobacco) Tobacco
5. If this insurance is issued, will it replace any insurance, annuity or other policy? Yes No
If "Yes," I also confirm that this Replacement is in accordance with the Company's position on Replacement cases. (See the reverse side of the Application coverage page.)
6. I hereby certify that to the best of my knowledge and belief the answers on the application and in this statement are true and correct.

_____ Soliciting Agent Signature _____ Code No. _____ Date _____ Year _____
 _____ Soliciting Agent Printed Name _____ Agent Business Phone # _____ Agent Fax # _____
 Agent E-mail Address: _____

7. Special requests, remarks and instructions:
8. **Referrals** Name: _____
Name: _____

Was this application faxed to the Home Office? Yes No
If yes, date faxed _____

9. Pre-Authorized Check (PAC) – Special monthly rate is 8.8% of annual premium.
 New PAC – Signed authorization and deposit ticket needed with application. Applications and/or policy numbers _____ to be included on this PAC.
 Add to existing PAC on: _____
 List Billing – Set up new list billing—complete Employer's Authorization and Case Agreement (form VBDIEA-97)
 List Billing _____ – Add to existing billing # _____
 to: Name of Company _____

For Home Office use only: Date received _____ Policy # _____ CWA \$ _____

APP-01-US (NE)

List Bill # here if adding this applicant to an existing list bill.

Step 6 HIPAA Forms

Both this form, DI/U 33, and the next, DI/U 33B, are required for release of medical information.

ASSURITY LIFE INSURANCE COMPANY
1526 K STREET • PO BOX 82533 • LINCOLN, NEBRASKA 68501-2533 • TOLL FREE 800-869-0355

AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL MEDICAL INFORMATION

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 ("Assurity") or 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.
- Information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.

I understand that this information may be released by Assurity 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 medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance (including additional coverage to an existing policy) and/or eligibility for benefits under a policy. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by Assurity 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 Assurity. 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, Assurity 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 notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request.

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.

Proposed insured must sign and date this form.

Signature of Proposed Insured or Personal Representative _____

Date _____

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

DI/U-33

Note: This authorization is intended to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Complete this form also for release of Medical Information

Both this form, DI/U-33, and the next, DI/U-33B, are required for release of medical information

ASSURITY LIFE INSURANCE COMPANY
1526 K STREET • PO BOX 82533 • LINCOLN, NEBRASKA 68501-2533 • TOLL FREE 800-869-0355

AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL MEDICAL INFORMATION

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 ("Assurity"), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Psychotherapy notes.

I understand that this information may be released by Assurity 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 Assurity 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 Assurity. 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, Assurity 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 notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request.

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.

Applicant also signs and dates this form

Signature of Proposed Insured or Personal Representative _____ Date _____

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

DI/U-33B

Note: This authorization is intended to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Step 7 Consumer Notice

Detach this page and give to the applicant.

ASSURITY LIFE INSURANCE COMPANY

1526 K Street • PO Box 82533

Lincoln, NE 68501-2533

Toll Free 800-869-0355

**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 and
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.

Step 8 Conditional Receipt

This form is only used when a FULL modal premium is taken.

Conditional Receipt

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

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

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

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

LU-CR (03/01) If premium collected, Proposed Insured/Owner should retain this page and complete Part B Part A

Part B

This form is given to applicant if full modal premium is taken. Do not collect premium if coverage is over \$5,000.

Conditional Receipt

Assurity Life Insurance Company • Lincoln, Nebraska

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

Amount taken

Name of client

1. The sum of \$ _____ is received of _____ by Assurity Life Insurance Company ("The Company") in payment of the full initial premium on insurance applied for on this date. Payment is accepted subject to the terms and limitations of this Conditional Receipt ("Receipt"). It is expressly understood and agreed that unless all conditions set forth in this Receipt are satisfied, or that unless the coverage applied for is issued within 60 days of the date of application, no insurance shall ever take effect. In such case, the Company's only liability and obligation is to promptly refund the premium payment received.
 2. If, on the applicable date, the Proposed Insured was acceptable for the plan and amount of insurance applied for, without modification, under Assurity's rules, limits and standards of insurability, coverage will be effective the later of i) the date of application, or ii) the date any medical examination of the Proposed Insured is completed, if required by the Company. Insurance will be issued at Assurity's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.
 - 3a. Assurity Life Insurance Company has NO liability for life insurance coverage if the answers to the health questions on the application indicate any significant health problems. Otherwise, the Company's total life insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that for which this Receipt is given) shall not exceed \$500,000 if all application health questions are answered, and shall not exceed \$100,000 if no application health questions are answered.
 - b. Assurity Life Insurance Company has NO liability for health insurance coverage and this Receipt is void for any insurance if any health questions on the application have not been answered and no medical examination is required of the Proposed Insured. Otherwise, the Company's total health insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that which this Receipt is given) shall not exceed \$2,500 per month.
- These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.
4. This Receipt must not be detached and used unless the full amount of the first premium is paid on the date of the application. Payment cannot be accepted with the application if any person proposed for coverage has been treated for or had any known heart trouble, stroke or cancer within the past twelve months. This Receipt is void if exchanged for any check or draft that is not honored upon first presentation for collection through usual banking facilities.

Dated: _____ Agent: _____

Date and Signed by Broker

LU-CR (03/01)

Proposed Insured/Owner should retain this page if premium is collected.

Part B

Step 9 PAC Form

ASSURITY LIFE INSURANCE COMPANY
1526 K Street • PO Box 82533 • Lincoln, NE 68501-2533
Phone: 800-869-0355 • Fax 800-437-4558

Automatic Bank Withdrawal

Automatic Bank Withdrawal conveniently pays your 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. 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.

DRAFT INITIAL PREMIUM PAYMENT: Yes No
If Yes is marked, the first premium for this insurance will be debited from your account at the time the policy is issued.

Mark source account

Name of Financial Institution Routing Number Account Number
(9 digit number beginning with 0, 1, 2, or 3)

Mark date the Client wants the withdrawal from their account

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

Type of account

Type of account: Checking Savings

Information on the account holder

Signature of Account Holder Date Signed Telephone Number

Voided check must be attached here. Do not copy bank information into this box or use the check received for the first premium.

Policy Number(s) (if applicable): _____

ATTACH VOIDED CHECK HERE

AC-11 (Rev. 12/04)

Step 10 For Life Only

If your state has approved the NAIC Model Regulation, you must furnish the Home Office with either a copy of the signed illustration or the signed Illustration Disclosure Statement.

If your state has not approved the NAIC Model regulation, the Home Office recommends an illustration still be forwarded with the application to help avoid errors in processing.

Assurity Life Insurance Company
1526 K Street • Box 82533
Lincoln, Nebraska 68501-2533
Telephone Toll-Free: (800) 276-7619, Ext. 4264

ILLUSTRATION DISCLOSURE STATEMENT

Proposed Insured's Knowledge and Agent's Certification of

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

PROPOSED INSURED ACKNOWLEDGEMENT

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

Proposed Insured's Signature

Date

Proposed must
sign and date

AGENT CERTIFICATION

I certify that:

- An illustration matching the application for insurance was not provided at time of sale for the reason marked above (if a computer screen application was used, it was based on the following:

Gender Age
Underwriting Class
Policy Type
Initial Death Benefit
Riders
Assumed Interest Rate

- I explained that a conforming illustration would be produced and delivered no later than at the time of policy delivery.
- I explained that any non-guaranteed elements for the policy are subject to change.
- I have made no statements that are inconsistent with the illustration that will be produced.

Agent signs
and dates

Agent Signature

Date

SA-18 (1/99)