Assurity
Life Insurance Company

Toll Free: **1-800-276-7619, Ext. 4264**
Extranet Address: **http://info.assurity.com**

Texas Application for Critical Illness Insurance

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

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

You may write a Life or Disability Income application* in combination with this Critical Illness application. In addition to this application, simply complete the appropriate Life or Disability Income section(s) obtained from the **Extranet** or from a Life or Disability Income application. The **advantages of writing a combined application** are:

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

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

✓ For Disability Income and Critical Illness products, the application should coincide with the **state in which the policy Owner resides** for the states listed below. (For Disability applications, the Proposed Insured and the policy Owner must be the same person.)

Disability Income (Form A-D109): CA, FL
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. NAIC Model Illustration or disclosure statement must accompany any whole life application.
2. Complete all other pertinent and applicable forms padded together in this application.

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 appsubmit@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.

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 ☐ M ☐ F
D. Date of Birth Mo. Day Year / /	E. Age Nearest birthday	F. Height Weight	G. Weight change in past year _____ lbs. ☐ loss ☐ gain	H. Birth State
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) Occupation: Duties:		B. Employer and address C. How long employed?		D. Gross average Monthly income (if not self-employed) If self-employed, net monthly income:

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 crew member? ☐ 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: _____

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?	Name/Address of Personal Physician
						Yes ☐ No ☐	
						Yes ☐ No ☐	
						Yes ☐ No ☐	
						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," 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. 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:
Fax: Phone:	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

Part 2 – Critical Illness Section

20. Name of spouse and/or dependent children (who have not reached their 19th birthday) proposed for coverage under the Spouse and/or Children's Rider. (Part 1 – General Section questions 11 and 15-19 apply.)

Full Name	Relationship	Sex M	Sex F	Date of Birth	Age	Height	Weight	Residing with Proposed Insured Yes	Residing with Proposed Insured No
	Spouse	☐	☐					☐	☐
	Child	☐	☐					☐	☐
	Child	☐	☐					☐	☐

21. Have any persons to be covered ever had symptoms of, been treated for, been advised to receive treatment, have had any investigation, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following? If *"yes,"* complete #22 below. Yes No

A. Heart attack, stroke, elevated or abnormal cholesterol, angina, coronary heart disease, disease of the blood vessels or TIA (Transient Ischemic Attack)? ☐ ☐
B. Thyroid disorder, hepatitis, hepatitis carrier, anemia, fatigue, disorder of the pancreas, any lupus or any other blood or glandular disorder? ☐ ☐
C. Polyp, mole, lump, other growth, breast disorder, abnormal mammogram or biopsy or abnormal PSA test? ☐ ☐
D. Have you ever used marijuana or any illegal or addictive drugs? ☐ ☐
E. Do you regularly take any medications (specify type and dosage)? ☐ ☐
F. Have you ever consulted any Physician within the last five years for which details are not given above? ☐ ☐
G. Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician? ☐ ☐
H. Have you been advised to have surgery, treatment or testing, which has not been completed? ☐ ☐

22. If any questions in #21 are answered "yes," indicate the questions letter and give complete details. If additional space is required, attach a separate page signed by the Proposed Insured. Details of all "Yes" answers for Question 21.

No.	Details

23. Has any immediate family member (whether living or deceased) ever suffered from, or is suffering from cancer (specify type), heart disease, stroke, kidney disease, diabetes, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease), motor neuron disease, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease prior to age 65? (If "Yes," please complete the chart below.) ☐ ☐

Person Proposed for Insurance	Family Member/ Relationship	Diagnosis	Age at Time of Diagnosis

24. Plan: Critical Illness

Premium Payment Method:
☐ Annually ☐ Quarterly
☐ Semi-Annually ☐ Monthly
☐ Other _____

Benefit Amount:
$_____
Amount Collected:
$_____

25. Optional Benefits
☐ Accidental Death Benefit $_____
☐ Children's Rider ☐ $5,000 ☐ $10,000
☐ Return of Premium
☐ Spouse Rider Benefit Amount $_____
☐ Waiver of Premium

26. The Primary Beneficiary (name and relationship) who survives the Proposed Insured: _____

27. Do you have any other Critical Illness insurance? ☐ Yes ☐ No If Yes, please indicate the name and address of the Company and the Policy Number: _____

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 & 2, Part 2 – Critical Illness 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 I have applied for is paid on the date of this application, the insurance under the policy shall take effect as provided in the Conditional Receipt and delivered by the Company's agent in exchange for the payment.
C. In the event the first full premium on the policy I have applied for is not paid on the date of this application, the insurance under the policy shall not take effect unless the application is approved by the Company at its Home Office, the policy is issued and delivered to Proposed Insured/Owner, and the first full premium paid during the Proposed Insured's lifetime and continued good health, and when the approval, issue, delivery and payment have occurred, the insurance under the policy shall take effect as of the date of issue stated in the policy.
D. No agent or medical examiner is authorized to change or waiver any term, provision or condition of this application, the Conditional Receipt, or the policy I have 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. _____

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.

   _____ _____ Date _____ Year _____
   Soliciting Agent Signature — Code No.

   _____ _____ _____
   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 $ _____

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

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 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.

_____

Signature of Proposed Insured or Personal Representative Date

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

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

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- 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.

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AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL MEDICAL INFORMATION

Name of Proposed Insured ("Applicant")_____

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- 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.

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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.

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

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TOLL FREE 800-276-7619, EXT. 4264

CONDITIONAL RECEIPT

Please Read Carefully!

TERMS AND CONDITIONS - Coverage issued bearing the date of this receipt will become effective on

- the later of the date of the application; or
- the date of completion of Part 2 – Critical Illness Section of the application; or
- the date of completion of the last medical requirements or tests required.

Coverage will be provided when the following conditions are met:

1. The application and complete evidence of insurability is received at our Home Office.
2. The Proposed Insured for coverage is insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid on the date of application. The maximum amount of critical illness insurance, which will become effective under this receipt, will be the lesser of the amount of insurance applied for or $50,000. This includes any pending critical illness insurance with Assurity Life Insurance Company.

If any check, draft, money-order or other instrument tended in payment of the amount specified hereof is not paid or honored, the said amount shall be considered unpaid and this receipt and acknowledgement of payment shall be null and void.

No conditional receipt coverage will have been in effect if any of the following apply:

a) the application is declined; or
b) the full first premium has not been paid; or
c) the policy is not issued exactly as applied for; or
d) there is insufficient evidence of insurability; or
e) the application is not approved within sixty days of its completion.

Any premium paid and not used to issue a policy of Critical Illness Insurance will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

ASSURITY LIFE INSURANCE COMPANY

PLAN _____ **Amount $**_____

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

_____ Date: _____
Agent's Signature

I agree to the terms of the Conditional Receipt set out above.

_____ Date: _____
Signature of the Proposed Insured

_____
Signature of the Owner (if other than Proposed Insured)

ASSURITY LIFE INSURANCE COMPANY
1526 K STREET ● PO BOX 82533 ● LINCOLN, NEBRASKA 68501-2533 ● TOLL FREE 800-276-7619, EXT. 4264

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

ASSURITY® LIFE INSURANCE COMPANY
1526 K Street, P.O. Box 82533, Lincoln, NE 68501
402.476.6500 • 800.276.7619 • FAX 402.437.4591

NOTICE AND CONSENT FOR HIV-RELATED TESTING

INSURER: Assurity Life Insurance Company • P.O. Box 82533 • 1526 K Street • Lincoln, Nebraska 68501-2533

To evaluate your insurability, the Insurer named above *(the Insurer)* has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus *(HIV)* antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS:
Many public health organizations have recommended that before taking an HIV-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT:
The test is not a test for AIDS. It is a test for the antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS:
All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law, or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULTS:
If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain the meaning.

_____
Name of physician for reporting a possible positive test result

_____
Address

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

CONSENT:
I have read and I understand this Notice of Consent for HIV-related testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____	_____
Name of Proposed Insured (Printed)	*Signature of Proposed Insured or Parent/Guardian*
_____	_____
Address	*Date Signed (MM/DD/YYYY)*

ASSURITY LIFE INSURANCE COMPANY
1526 K Street - PO Box 82533
Lincoln, NE 68501-2533
Toll Free 800-276-7619, Ext. 4264

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Assurity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded. The above "Notice to Applicant" was delivered to me on:_____
Date

_____
Applicant's Signature

Signed form to be returned to Home Office
Applicant to receive a copy of signed form at time the application is taken

ASSURITY LIFE INSURANCE COMPANY
1526 K Street - PO Box 82533
Lincoln, NE 68501-2533
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Date

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Applicant's Signature

Signed form to be returned to Home Office
Applicant to receive a copy of signed form at time the application is taken

ASSURITY LIFE INSURANCE COMPANY
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Lincoln, NE 68501-2533
Toll Free 800-276-7619, Ext. 4264

TEXAS GUARANTY FUND DISCLOSURE STATEMENT

Important Information About Coverage Under the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association.

Texas law establishes a system, administered by the Texas life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify.) the law is found in the Texas Insurance Code, Article 21.28-D.)

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company, which is a member of the Association, is designated as impaired by the Texas by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at the time that their insurance company is impaired; or
- Residents of other states, ONLY if the following conditions are met:
  1. The Policyholder has a policy with a company based in Texas;
  2. The company has never held a license in the policyholder's state of residence;
  3. The policyholder's state of residence has a similar guaranty association; and
  4. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by Association

Accident, Accident and Health, or Health Insurance

- Up to a total of $200,000 for one or more policies for each individual covered.

Life Insurance

- Net cash surrender value up to a total of $100,000 under one or more policies on any one life; or
- Death benefits up to a total of $300,000 under one or more policies on any one life.

Annuities

- Net cash surrender amount up to a total of $100,000 under one or more policies owned by one contract holder.

Group Annuities

- Net cash surrender amount up to $100,000 in allocated benefits under one or more policies owned by one contract holder; or
- Net cash surrender amount up to $5,000,000 in unallocated benefits under one contract holder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORMS OR INSURANCE.
When you are selecting an insurance company, you should not rely on coverage by the Association.

Texas Life, Accident Health and
Hospital Service Insurance
Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, TX 78730
800-982-6362
www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
800-252-3439

Applicant to receive a copy of form at time the Application is taken

ASSURITY LIFE INSURANCE COMPANY
1526 K Street • PO Box 82533 • Lincoln, NE 68501-2533
Phone: 800-276-7619, Ext. 4264 • Fax 402-437-4558

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.

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

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: ☐ Checking ☐ Savings

Signature of Account Holder	Date Signed	Telephone Number

Policy Number(s) (if applicable): _____ _____ _____ _____

ATTACH VOIDED CHECK HERE