Assurity
Life Insurance Company

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

Florida Application for Life Insurance

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

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

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

✓ If applying for whole life coverage and the proposed insured is a juvenile, the following riders are available: Protected Insurability Benefit Rider, Accidental Death Benefit Rider, Payor Benefit Rider and Paid-Up Additions Rider (VER).

✓ The application should coincide with the **state where the application is signed**. State specific applications and state forms can be found on AssureLINK.

✓ 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 (877) 864-6630.

✓ If mailing directly to the Home Office, address to:

Assurity Life Insurance Company
Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

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

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

Application for LIFE INSURANCE

PLEASE PRINT IN BLUE OR BLACK INK

1. PROPOSED INSURED

Legal Name (*First, Middle, Last*) | Date of Birth (*MM/DD/YYYY*) / /

Social Security No. | ☐ Male ☐ Female | E-mail | Age

Home Address (*Street Address, City, State, ZIP+4*)

Personal Phone No. ( ) | Birth State/Country | Height ft. in. | Weight lbs.

During the past **12 months**, has the Proposed Insured used any form of tobacco, nicotine-based products or substitutes such as patches or gum? ☐ Yes ☐ No

If YES, please list type: amount per day: last date of use (*MM/DD/YYYY*) / /

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If the Proposed Insured has permanent resident status, please list permanent resident *(green card)* number.

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number.

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No Length of employment (*Years Months*) /

Primary Employer | Employer's Address (*Street Address, City, State, ZIP+4*)

Full-time Employment (*Occupation, Duties*) | Part-time Employment (*Occupation, Duties*)

Gross monthly income $ | If self-employed, net monthly income $

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

If Ownership is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

Legal Name (*First, Middle, Last*) | Date of Birth (*MM/DD/YYYY*) / /

Social Security No. | Relationship to Insured | Birth State/Country

Home Address (*Street Address, City, State, ZIP+4*) | E-mail

Contingent Owner's Name (*First, Middle, Last*) | Contingent Owner's Relationship to Insured

3. BENEFICIARIES

If Beneficiary is a trust, or if additional space is needed, complete the Trust Information/Additional Beneficiary form.

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Soc. Sec. No.**	**Date of Birth**	**Share %**
			/ /	
			/ /	

4. PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below:

Type

☐ Direct Billing ☐ ~~Automatic Credit Card~~
☐ List Billing *(employer)* ☐ Automatic Bank Withdrawal

Frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ Monthly *(not available with Direct Billing)*

Payor Name (*First, Middle, Last*) | Billing Address (*Street Address, City, State, ZIP+4*)

Secondary Payor Info. (*First, Middle, Last*) | Billing Address (*Street Address, City, State, ZIP+4*)

5. SECONDARY ADDRESSEE

Legal Name (*First, Middle, Last*) | Relationship to Insured

Home Address (*Street Address, City, State, ZIP+4*)

TRUST INFORMATION/ADDITIONAL BENEFICIARY

Please complete the following sections if Ownership and/or Beneficiary is a trust *(or if additional room is needed to list beneficiaries of Policy)*:

1. POLICYOWNER

Name of Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Address of Trustee(s) *Street Address* *City* *State* *ZIP+4*

2. BENEFICIARIES

☐ Testamentary Trust *(Will)* Share % _____

☐ Living Trust *(Please complete information below.)* Share % _____

Name of Living Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Street Address *City* *State* *ZIP+4*

Address of Trustee(s)

3. ADDITIONAL BENEFICIARIES *(Do not complete if applying for Reversionary Annuity)*

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Social Security No.**	**Date of Birth *(MM/DD/YYYY)***	**Share %**
			/ /	
			/ /	
			/ /	
			/ /	
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			/ /	

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or within the next **12 months** intend to join, the National Guard or military? ☐ Yes ☐ No

2. During the past **5 years** or within the next **12 months**:

   a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured planning flying as a pilot, crew member or student? ☐ Yes ☐ No

   b. Has any Proposed Insured participated in, or planning participation in, any of the hazardous sports or activities listed below? ☐ Yes ☐ No

   If YES, check all that apply:
   ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/Hang Gliding
   ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports
   ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning

3. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No
   If YES, please list Proposed Insured's name, amount of weight change and reason for change:

   _____

4. During the past **5 years**, has any Proposed Insured:

   a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? ☐ Yes ☐ No

   If YES, please explain _____

   b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ Yes ☐ No

   If YES, please explain _____

5. Is any Proposed Insured currently applying for other insurance coverage? ☐ Yes ☐ No

   If YES, please explain _____

6. During the past **5 years**, has any Proposed Insured:

   a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence *(DUI/DWI)*, or had more than 3 moving violations? ☐ Yes ☐ No

   If YES, please explain _____

   b. Been convicted of a felony? ☐ Yes ☐ No

   If YES, please explain _____

7. Is any Proposed Insured currently on probation? ☐ Yes ☐ No
   If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

   _____

8. a. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No
   If YES, please provide details below.

   b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
   If YES, please complete and return the appropriate State Replacement Form.

Insured's Name	Company Name	Policy No.	Individual (I) Group (G)	Benefits *(monthly benefit and benefit period for DI or face amount for Life)*	Issue Date *(MM/DD/YYYY)*	DI Coverage Only: Coordinates w/ Soc. Sec.?	DI Coverage Only: Employer Paid?
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No

9. **If the Proposed Insured is a juvenile,** please list the total amount of life insurance in force and pending on **all** family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
$	$	$	$	$	$	$

HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 5.

1. Has any Proposed Insured **ever** consulted with or been diagnosed, treated, hospitalized or prescribed medication by a licensed medical professional for any of the following:

   a. Heart disorder, including a heart attack *(myocardial infarction)*, angina, irregular heartbeat or abnormal heart rhythm *(arrhythmia)*, chest pain, hypertension *(high blood pressure)*, heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack *(TIA or mini-stroke)*, or rheumatic fever? ☐ Yes ☐ No

   b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease *(other than kidney stones)*, protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, thyroid, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? ☐ Yes ☐ No

   c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? ☐ Yes ☐ No

   d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation *(including Down's syndrome)*, multiple sclerosis *(MS)*, muscular dystrophy *(MD)*, Parkinson's disease, amyotrophic lateral sclerosis *(ALS)*, any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy? ☐ Yes ☐ No

   e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease *(COPD)*, shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder *(lupus or scleroderma)*? ☐ Yes ☐ No

   f. Dizziness, headaches, migraines, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? ☐ Yes ☐ No

   g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? ☐ Yes ☐ No

   h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? ☐ Yes ☐ No

   i. Any disease or disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No

   j. Any other illness or injury requiring medical attention or blood transfusions? ☐ Yes ☐ No

2. During the past **5 years**, has any Proposed Insured:

   a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? ☐ Yes ☐ No

   b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? ☐ Yes ☐ No

   c. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? ☐ Yes ☐ No

   d. Been advised by a licensed medical professional to have any test *(except HIV tests)*, treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received? ☐ Yes ☐ No

   e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests *(other than AIDS-related blood tests)* or urine tests? ☐ Yes ☐ No

3. To the best of my knowledge and belief, has any Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death. ☐ Yes ☐ No

   _____

4. To the best of my knowledge and belief:

   a. Has any Proposed Insured **ever** been diagnosed by or received treatment from a licensed medical professional for any genital or reproductive organ disorder, miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No

   b. Has any Proposed Insured been diagnosed by a licensed medical professional as being pregnant? ☐ Yes ☐ No

      If YES, date child is expected *(MM/DD/YYYY)* ____/____/_____

   c. Is any Proposed Insured currently receiving treatment from a licensed medical professional for pregnancy? ☐ Yes ☐ No

5. Has any Proposed Insured **ever** been tested positive for exposure to the human immunodeficiency virus *(HIV)* infection or been diagnosed as having AIDS-related complex *(ARC)*, or acquired immune deficiency syndrome *(AIDS)*, caused by the HIV infection, or other sickness or condition derived from such infection? ☐ Yes ☐ No

   If YES, please list name(s) of Proposed Insured(s) _____

DETAILS: Enter complete details from questions #1-4 on page 5. If more space is needed, attach additional Supplemental Information form.

SUPPLEMENTAL INFORMATION

Question #/Letter	Name *(First, Middle, Last)*	Onset Date *(MM/DD/YYYY)*	Duration *(Days, Mos, Yrs)*	Health Condition and Details	Medical Care Provider's Name/Address/Phone
		/ /			
		/ /			
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Additional Information:

LIFE PRODUCT SECTION

What is the purpose of this insurance? ☐ Personal ☐ Key Person ☐ Buy/Sell ☐ Business Loan ☐ Charitable Giving ☐ Other _____

TERM LIFE INSURANCE

Face Amount $ _____ Number of years for policy: ☐ 10-Year ☐ 15-Year ☐ 20-Year ☐ 30-Year

ADDITIONAL BENEFITS AVAILABLE ON TERM LIFE—Check benefit(s) desired and indicate amount requested where applicable.

☐ Disability Waiver of Premium Benefit Rider

☐ Other Insured Term Insurance Benefit Rider *(complete next page)* $ _____

☐ Monthly Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Monthly Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Children's Term Insurance Rider *(complete next page)* _____ units

☐ Return of Premium Benefit Rider

WHOLE LIFE INSURANCE

Face Amount $ _____

If cash value is available, should the Automatic Premium Loan *(APL)* provision be made effective? *(If no option chosen, APL will apply.)* ☐ Yes ☐ No

Nonforfeiture Option: *(If no option chosen, ETI will apply)* ☐ Extended Term Insurance *(ETI)* ☐ Reduce Paid-Up Insurance *(RPU)*

Dividend Option: *(If no option chosen, PUA will apply)* ☐ Paid-up Additions *(PUA)* ☐ Accumulate at Interest ☐ Reduce Premium/PUA ☐ Reduce Premium/Cash ☐ Paid in Cash

ADDITIONAL BENEFITS AVAILABLE ON WHOLE LIFE—Check benefit(s) desired and indicate amount requested where applicable.

☐ Disability Waiver of Premium Benefit Rider

☐ Protected Insurability Benefit Rider $ _____

☐ Monthly Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Monthly Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Primary Insured $ _____ mo. benefit

☐ Accident Only Disability Income Rider for Other Insured *(complete next page)* $ _____ mo. benefit

☐ Children's Term Insurance Rider *(complete next page)* _____ units

☐ Accidental Death Benefit Rider $ _____

☐ Level Term Insurance Benefit Rider for Primary Insured *(Select only one)*: ☐ 10-Year ☐ 20-Year $ _____

☐ Level Term Insurance Benefit Rider — Other Insured *(Select only one)*: ☐ 10-Year ☐ 20-Year $ _____

☐ Payor Benefit Rider *(Complete Health Section for Payor)* Payor Name _____ DOB ___/___/___ ☐ M ☐ F

☐ Paid-Up Additions Rider *(VER)* ☐ Periodic Premiums $ _____ ☐ Single Premium $ _____

SINGLE PREMIUM WHOLE LIFE INSURANCE

Face Amount $ _____

Dividend Option: *(If no option chosen, PUA will apply)* ☐ Paid-Up Additions *(PUA)* ☐ Paid in Cash

OTHER INSURED AND CHILD RIDER INFORMATION—If additional space is needed, attach a separate sheet of paper.

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name *(First, Middle, Last)*				
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to Proposed Insured				
Employer				
Occupation/Duties				
Gross monthly income	$			
If self-employed, net monthly income	$			

Has the Other Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No *(Not applicable to Child Riders.)*

If YES, please list type: amount per day: last date of use *(MM/DD/YYYY)* / /

Is the Other Insured a United States citizen, or does the Other Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If the Other Insured has permanent resident status, please list permanent resident *(green card)* number.

Does the Other Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number .

PHYSICIAN INFORMATION

Please list the last physician seen:

Name _____ Date last consulted ____/____/____
MM/DD/YYYY

Address _____
Street Address *Suite*

_____
City *State* *ZIP+4*

Phone No. (____) _____ Fax No. (____) _____

Is this your primary physician? ☐ Yes ☐ No

Reason for consultation _____

Results _____

_____

AGREEMENT

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 shall form a part of the policy if attached thereto.

I *(We)* agree that:

a. 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 Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.

b. 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: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. 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.

c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Substitute Form W-9 information *(Request for Taxpayer Identification Number and Certification)*: I, the Owner *(or each Joint Owner)*, certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person *(including a U.S. resident alien)*. The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____ on ____/____/____
City *State* *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured *Signature of Additional Proposed Insured*

_____ _____
Signature of Parent/Guardian of Minor Child *Signature of Additional Proposed Insured*

_____
Signature of Owner(s) (If other than Proposed Insured)

_____ _____
Signature of Licensed Agent *Print Agent Name*

_____ _____
Agent No. *Agent's Florida License No.*

FIELD UNDERWRITER'S STATEMENT

1. a. What amount was collected with this application? $ _____

   b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ☐ No

   c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ☐ Yes ☐ No

2. a. Did you personally see all Proposed Insured(s) on the date of application? ☐ Yes ☐ No

   b. How well do you know the Proposed Insured(s)? ☐ Well ☐ Slightly ☐ 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? If YES, please provide details below. ☐ Yes ☐ No

   _____

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ☐ Yes ☐ No
   Agent is responsible for scheduling exam items.
   NOTE: ANY PREFERRED PLANS REQURE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.
   ☐ Paramedical examination ☐ Blood Sample ☐ Urine Sample ☐ Electrocardiogram *(EKG)* ☐ Treadmill EKG ☐ Medical exam by physician

4. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

5. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No

6. Was sales material used in soliciting this application? ☐ Yes ☐ No

7. Was the sales material left with the applicant? ☐ Yes ☐ No

8. Was the sales material approved by Assurity Life Insurance Company? ☐ Yes ☐ No

9. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ _____% Agent No. _____ _____%

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.

☐ Add to existing bank withdrawal—indicate other applicant and/or policy numbers _____

~~☐ Set up NEW credit card payment—submit signed authorization with the application.~~

LIST BILL

☐ Set up NEW list bill— submit signed authorization with the application.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

FOR TERM LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:

$350,000 and under: ☐ Select + NT ☐ Select NT ☐ Standard NT ☐ Select + T ☐ Select T ☐ Standard T

$350,001 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Standard NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

FOR WHOLE LIFE APPLICATION *(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)*

The premiums for this application were quoted on the following underwriting classification:

$99,999 and under: ☐ Select NT ☐ Standard T

$100,000 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

FOR UNIVERSAL LIFE APPLICATION *(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)*

The premiums for this application were quoted on the following underwriting classification:

☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Additional Insured's underwriting classification _____

FOR REVERSIONARY ANNUITY APPLICATION *(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)*

The premiums for this application were quoted on the following underwriting classification: ☐ Preferred NT ☐ Standard NT ☐ Tobacco

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____	/ / _____	( ) / ( ) _____
Signature of Soliciting Agent	*Date (MM/DD/YYYY)*	*Business Phone No. and Fax No.*
_____	_____	_____
Soliciting Agent's Printed Name/Agent No.	*Florida License No.*	*Agent's E-mail*

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

Confidential Information AUTHORIZATION

_____ / / _____
Name of Applicant/Insured/Claimant (Please print) *Date of Birth (MM/DD/YYYY)*

_____ / / _____
Name of Additional Applicant/Insured/Claimant (Please print) *Date of Birth (MM/DD/YYYY)*

Applicant/Insured/Claimant Child(ren)

Name	*Date of Birth*	*Name*	*Date of Birth*

I, on behalf of myself or the person named above *(Individual)*, 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, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their 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 the 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 Individuals residing in Maine or Vermont.).* **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual 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 Individual 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 Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications 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 Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual 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 Individual do not apply to this authorization, and I instruct 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, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual'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 this information may be subject to re-disclosure by Assurity and 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, policy reinstatement or claim. 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 Assurity. 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, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

_____
Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (888) 255-2060

CONSUMER NOTICE

MIB Pre-Notice

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

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 *(TTY 866-346-3642)*. If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, Assurity will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices, please direct your requests to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended *(15 U.S.C. 1681d)*, notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, Assurity Life Insurance Company *(Assurity)* may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation Assurity requests. Please direct this written request to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Upon receipt of such a request, Assurity will respond by mail within five business days.

Telephone Interview Information

Assurity may require that you complete a confidential telephone interview as a part of your application for insurance. The interview will be conducted by a trained professional and may include *(but is not limited to)* the following topics: occupation, job history, income, personal and business financial information and medical history. All information obtained will be used for underwriting purposes only and will not be released without your written consent.

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

Temporary Conditional Insurance Agreement

(for use with Life and Reversionary Annuity products)

Proposed Insured No. 1 _____ Date Application Signed ___/___/___

Proposed Insured No. 2 _____ Date Application Signed ___/___/___

In consideration of the premium received with the life insurance application listed above *(Application)*, Assurity Life Insurance Company *(Assurity)* will provide temporary life insurance coverage subject to the terms and conditions contained in this Agreement. Make all checks payable to Assurity. Do not make checks payable to the agent. Do not leave the check payee blank.

NOTE: On questions 1-2 answer according to what product(s) is being applied for.
If questions 3 a-d are answered YES or are left BLANK, there will be NO CONDITIONAL COVERAGE
The agent is not authorized to accept a premium under these circumstances.

1. a. **LIFE—**Is any Proposed Insured younger than 15 days old or older than 75 years old? ☐ Yes ☐ No
   b. **LIFE—**Does the Application, combined with the total amount of insurance in force on any Proposed Insured's life with Assurity exceed $500,000 for ages 15 days through 69 years? ***or*** $250,000 for ages 70 through 75? ☐ Yes ☐ No
2. **Reversionary Annuity—**Does the in-force and applied for life coverage, including the present value of any reversionary annuity policy exceed $100,000? ☐ Yes ☐ No
3. Has any Proposed Insured:
   a. **Ever** been diagnosed or treated by a medical professional for a heart, lung, liver or kidney disease or disorder; diabetes; stroke; paralysis or cancer? ☐ Yes ☐ No
   b. **Ever** been tested positive for exposure to the human immunodeficiency virus *(HIV)* infection, or been diagnosed as having AIDS-related complex *(ARC)* or acquired immune deficiency syndrome *(AIDS)* caused by the HIV infection, or other sickness or condition derived from such infection? ☐ Yes ☐ No
   c. During the past **5 years** been treated, counseled or advised by a medical professional to seek treatment for drug/alcohol abuse? ☐ Yes ☐ No
   d. During the past **90 days** been admitted, or advised by a medical professional to be admitted to a hospital or other licensed health care facility; had surgery or had surgery recommended by a medical professional; or been advised by a medical professional to have any diagnostic test that was not completed *(excluding an AIDS-related test)*? ☐ Yes ☐ No

No coverage starts:

- Until the later of **1)** the date the Proposed Insured completed and signed the Application and paid the first full modal premium *(a check is not payment unless honored by the issuing institution when first presented)*; or **2)** the date the Proposed Insured completed all medical tests required by Assurity **and**
- Unless the Proposed Insured is insurable on the date coverage starts at Assurity's **standard or better than average rates** *(no ratings included)*, according to its underwriting practices for the amount of insurance and any additional benefits applied for.

If Proposed Insured dies while coverage under this Agreement is in effect, Assurity will pay the death benefit payable if the Policy applied for would have been issued at standard rates. However, Assurity shall not be liable for payment of any benefit over the amount of $500,000 *($250,000 for ages 70 through 75)*. Coverage under this Agreement is subject to the same terms, including any limitations or exclusions, which would be part of the Policy if issued as applied for.

If no Policy is issued and delivered and no benefit is paid under this Agreement, all premiums paid will be returned. If the Policy is issued as applied for, or if a Policy amendment is accepted by the Proposed Owner, premium paid will be applied to that Policy. No change in health will be used to deny a Policy if the change occurs after the later of: **1)** the date of the Application; or **2)** completion of all medical tests required by Assurity.

Coverage under this Agreement terminates automatically on the earliest of the date:

- 90 days from the date of the Application;
- Premium is returned by Assurity *(return is effective on being postmarked, properly addressed and postage prepaid)*;
- Coverage starts under any Policy resulting from the Application; or
- A Policy resulting from the Application is refused by the Proposed Owner.

The undersigned states that the answers on this Agreement and the Application are true and complete to the best of his/her knowledge and belief, and understands that the answers are relied upon for coverage under this Agreement. Assurity's liability will be limited to a return of the premium submitted if: **1)** the Proposed Insured dies by suicide; or **2)** the Application or this Agreement contains a material misrepresentation to Assurity.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Dated at _____ On _____
City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

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

Temporary Conditional Insurance Agreement

(for use with Life and Reversionary Annuity products)

Proposed Insured No. 1 _____ Date Application Signed ___/___/___

Proposed Insured No. 2 _____ Date Application Signed ___/___/___

In consideration of the premium received with the life insurance application listed above *(Application)*, Assurity Life Insurance Company *(Assurity)* will provide temporary life insurance coverage subject to the terms and conditions contained in this Agreement. Make all checks payable to Assurity. Do not make checks payable to the agent. Do not leave the check payee blank.

NOTE: On questions 1-2 answer according to what product(s) is being applied for.
If questions 3 a-d are answered YES or are left BLANK, there will be NO CONDITIONAL COVERAGE
The agent is not authorized to accept a premium under these circumstances.

1. a. **LIFE—**Is any Proposed Insured younger than 15 days old or older than 75 years old? ☐ Yes ☐ No
   b. **LIFE—**Does the Application, combined with the total amount of insurance in force on any Proposed Insured's life with Assurity exceed $500,000 for ages 15 days through 69 years? ***or*** $250,000 for ages 70 through 75? ☐ Yes ☐ No
2. **Reversionary Annuity—**Does the in-force and applied for life coverage, including the present value of any reversionary annuity policy exceed $100,000? ☐ Yes ☐ No
3. Has any Proposed Insured:
   a. **Ever** been diagnosed or treated by a medical professional for a heart, lung, liver or kidney disease or disorder; diabetes; stroke; paralysis or cancer? ☐ Yes ☐ No
   b. **Ever** been tested positive for exposure to the human immunodeficiency virus *(HIV)* infection, or been diagnosed as having AIDS-related complex *(ARC)* or acquired immune deficiency syndrome *(AIDS)* caused by the HIV infection, or other sickness or condition derived from such infection? ☐ Yes ☐ No
   c. During the past **5 years** been treated, counseled or advised by a medical professional to seek treatment for drug/alcohol abuse? ☐ Yes ☐ No
   d. During the past **90 days** been admitted, or advised by a medical professional to be admitted to a hospital or other licensed health care facility; had surgery or had surgery recommended by a medical professional; or been advised by a medical professional to have any diagnostic test that was not completed *(excluding an AIDS-related test)*? ☐ Yes ☐ No

No coverage starts:

- Until the later of **1)** the date the Proposed Insured completed and signed the Application and paid the first full modal premium *(a check is not payment unless honored by the issuing institution when first presented)*; or **2)** the date the Proposed Insured completed all medical tests required by Assurity **and**
- Unless the Proposed Insured is insurable on the date coverage starts at Assurity's **standard or better than average rates** *(no ratings included)*, according to its underwriting practices for the amount of insurance and any additional benefits applied for.

If Proposed Insured dies while coverage under this Agreement is in effect, Assurity will pay the death benefit payable if the Policy applied for would have been issued at standard rates. However, Assurity shall not be liable for payment of any benefit over the amount of $500,000 *($250,000 for ages 70 through 75)*. Coverage under this Agreement is subject to the same terms, including any limitations or exclusions, which would be part of the Policy if issued as applied for.

If no Policy is issued and delivered and no benefit is paid under this Agreement, all premiums paid will be returned. If the Policy is issued as applied for, or if a Policy amendment is accepted by the Proposed Owner, premium paid will be applied to that Policy. No change in health will be used to deny a Policy if the change occurs after the later of: **1)** the date of the Application; or **2)** completion of all medical tests required by Assurity.

Coverage under this Agreement terminates automatically on the earliest of the date:

- 90 days from the date of the Application;
- Premium is returned by Assurity *(return is effective on being postmarked, properly addressed and postage prepaid)*;
- Coverage starts under any Policy resulting from the Application; or
- A Policy resulting from the Application is refused by the Proposed Owner.

The undersigned states that the answers on this Agreement and the Application are true and complete to the best of his/her knowledge and belief, and understands that the answers are relied upon for coverage under this Agreement. Assurity's liability will be limited to a return of the premium submitted if: **1)** the Proposed Insured dies by suicide; or **2)** the Application or this Agreement contains a material misrepresentation to Assurity.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Dated at _____ On _____
City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

ASSURITY® LIFE INSURANCE COMPANY
1526 K Street, P.O. Box 82533, Lincoln, NE 68501
402.476.6500 • 800.276.7619 • FAX 402.437.4588

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

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

EXAMINER: _____
Name *Address*

CONSENT FOR HIV TESTING
To evaluate your insurability, the insurer named above *(the Insurer)* has requested that you provide a sample of your blood or other bodily fluids 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 results. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS
Many public health organizations have recommended that before taking an AIDS-related blood 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 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 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.

CONFIDENTIALITY OF TEST RESULTS
All test results are required to be treated confidentially. Results 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 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 RESULT
A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida 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 its meaning.

Name of physician for reporting a positive test result _____

Physician's address _____
Street Address *City* *State* *Zip*

CONSENT
I have read and I understand this Notice and Consent for AIDS-Related Blood Testing. I voluntarily consent to the withdrawal of blood form me, the testing of that blood, and the disclosure of the test results described above.

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.

_____ _____
Signature of Proposed Insured or Legal Representative *Date Signed (MM/DD/YYYY)*

_____
Name of Proposed Insured (Printed)

_____
Address of Proposed Insured *City* *State* *Zip*

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

Life Insurance
REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarized your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ Yes ☐ No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

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

_____ _____
Applicant's Signature and Printed Name *Date (MM/DD/YYYY)*

_____ _____
Agent's Signature and Printed Name *Date (MM/DD/YYYY)*

_____
Agent's Address (Print) *Street Address* *City* *State* *Zip*

_____
Agent's Company (Print)

Information on policies which may be replaced:

COMPANY NAME	POLICY NO.	NAME OF INSURED

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

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

Life Insurance
REPLACEMENT NOTICE

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

_____
Proposed Insurer

_____
Insurer's Address

_____
Replacing Agent's Name

APPLICANT INFORMATION

Name _____

Address _____

_____

Telephone ( ) _____

Date of Birth _____ Age _____

POLICY INFORMATION

Policy Generic Name _____

Policy Number _____

Date of Issue _____ Issue Age _____

Contestable Period Expires _____

Suicide Period Expires _____

Policy Loan Rate _____

POLICY/RIDER DESCRIPTION

Policy/Rider Name	Initial/Continuing Benefit	*(Age)* Benefit From — To	Initial/Renewable Annual Premium	*(Age)* Payable From — To

Total Initial Annual Premium $ _____ Mode of Payment _____ Amount $ _____

Total Renewal Annual Premium $ _____ Amount $ _____

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

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

	GUARANTEES				PROJECTIONS *			
Year/ Age	Annual Premium	Cumulative Premium	Cash Value	Death Benefit	Annual Premium	Cumulative Premium	Cash Value	Death Benefit
1st								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
9th								
10th								
11th								
12th								
13th								
14th								
15th								
16th								
17th								
18th								
19th								
20th								

55								
60								
65								
70								
75								
85								
95								

*Projections include dividends and current interest rates which are not guaranteed.

IMPORTANT NOTICE:

The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implication.

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

ASSURITY® LIFE INSURANCE COMPANY
1526 K Street, P.O. Box 82533, Lincoln, NE 68501
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Life Insurance
REPLACEMENT NOTICE

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

_____
Existing Insurer

_____
Insurer's Address

APPLICANT INFORMATION

Name _____

Address _____

_____

Telephone ( ) _____

Date of Birth _____ Age _____

POLICY INFORMATION

Policy Generic Name _____

Policy Number _____

Date of Issue _____ Issue Age _____

Contestable Period Expires _____

Suicide Period Expires _____

Policy Loan Rate _____

POLICY/RIDER DESCRIPTION

Policy/Rider Name	Initial/Continuing Benefit	*(Age)* Benefit From — To	Initial/Renewable Annual Premium	*(Age)* Payable From — To

Total Initial Annual Premium $ _____ Mode of Payment _____ Amount $ _____

Total Renewal Annual Premium $ _____ Amount $ _____

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

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

	GUARANTEES				PROJECTIONS *			
Year/ Age	Annual Premium	Cumulative Premium	Cash Value	Death Benefit	Annual Premium	Cumulative Premium	Cash Value	Death Benefit
Current								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
9th								
10th								
11th								
12th								
13th								
14th								
15th								
16th								
17th								
18th								
19th								
20th								

55								
60								
65								
70								
75								
85								
95								

*Projections include dividends and current interest rates which are not guaranteed.

IMPORTANT NOTICE:

The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implication.

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

INSTRUCTIONAL NOTES FOR COMPLETION OF COMPARATIVE INFORMATION FORM

1. Existing life insurance must be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, an alternative identification form such as an application or receipt number must be shown.

2. If more than one existing life insurance policy is to be replaced, a separate Comparative Information Form is to be provided for each such policy.

3. In the disclosure of values, premiums shall be shown only if they increase the cash value or death benefits for the primary insured.

4. Any benefits for secondary insureds shall be shown on a supplementary exhibit.

5. Values will be shown for each year in which either an initial change in face value or premium payment occurs.

6. Values will be shown in the disclosure for the maximum duration policy guarantees permit. If this benefit extension requires that guaranteed policy options be utilized, the option to be used will be that *(those)* automatically utilized by the issuing insurer. However, if the policy application provides for applicant election, then the extension of benefits will employ the option actually elected by the applicant. Any option utilized for extension of benefits must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form.

7. The dividend option elected by an insured or applicant must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form. The dividend option elected by the insured or applicant must be employed in completing the disclosure of values.

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

Life Insurance
REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarized your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ Yes ☐ No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

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

_____ _____
Applicant's Signature and Printed Name *Date (MM/DD/YYYY)*

_____ _____
Agent's Signature and Printed Name *Date (MM/DD/YYYY)*

_____
Agent's Address (Print) *Street Address* *City* *State* *Zip*

_____
Agent's Company (Print)

Information on policies which may be replaced:

COMPANY NAME	POLICY NO.	NAME OF INSURED

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

ASSURITY® LIFE INSURANCE COMPANY
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402.476.6500 • 800.276.7619 • FAX 402.437.4591

Life Insurance
REPLACEMENT NOTICE

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

_____
Proposed Insurer

_____
Insurer's Address

_____
Replacing Agent's Name

APPLICANT INFORMATION

Name _____

Address _____

_____

Telephone ( ) _____

Date of Birth _____ Age _____

POLICY INFORMATION

Policy Generic Name _____

Policy Number _____

Date of Issue _____ Issue Age _____

Contestable Period Expires _____

Suicide Period Expires _____

Policy Loan Rate _____

POLICY/RIDER DESCRIPTION

Policy/Rider Name	Initial/Continuing Benefit	*(Age)* Benefit From — To	Initial/Renewable Annual Premium	*(Age)* Payable From — To

Total Initial Annual Premium $ _____ Mode of Payment _____ Amount $ _____

Total Renewal Annual Premium $ _____ Amount $ _____

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

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

	GUARANTEES				PROJECTIONS *			
Year/ Age	Annual Premium	Cumulative Premium	Cash Value	Death Benefit	Annual Premium	Cumulative Premium	Cash Value	Death Benefit
1st								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
9th								
10th								
11th								
12th								
13th								
14th								
15th								
16th								
17th								
18th								
19th								
20th								

55								
60								
65								
70								
75								
85								
95								

*Projections include dividends and current interest rates which are not guaranteed.

IMPORTANT NOTICE:

The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implication.

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

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

Life Insurance
REPLACEMENT NOTICE

COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

_____
Existing Insurer

_____
Insurer's Address

APPLICANT INFORMATION

Name _____

Address _____

_____

Telephone ( ) _____

Date of Birth _____ Age _____

POLICY INFORMATION

Policy Generic Name _____

Policy Number _____

Date of Issue _____ Issue Age _____

Contestable Period Expires _____

Suicide Period Expires _____

Policy Loan Rate _____

POLICY/RIDER DESCRIPTION

Policy/Rider Name	Initial/Continuing Benefit	*(Age)* Benefit From — To	Initial/Renewable Annual Premium	*(Age)* Payable From — To

Total Initial Annual Premium $ _____ Mode of Payment _____ Amount $ _____

Total Renewal Annual Premium $ _____ Amount $ _____

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

COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

	GUARANTEES				PROJECTIONS *			
Year/ Age	Annual Premium	Cumulative Premium	Cash Value	Death Benefit	Annual Premium	Cumulative Premium	Cash Value	Death Benefit
Current								
2nd								
3rd								
4th								
5th								
6th								
7th								
8th								
9th								
10th								
11th								
12th								
13th								
14th								
15th								
16th								
17th								
18th								
19th								
20th								

55								
60								
65								
70								
75								
85								
95								

*Projections include dividends and current interest rates which are not guaranteed.

IMPORTANT NOTICE:

The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implication.

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

INSTRUCTIONAL NOTES FOR COMPLETION OF COMPARATIVE INFORMATION FORM

1. Existing life insurance must be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, an alternative identification form such as an application or receipt number must be shown.

2. If more than one existing life insurance policy is to be replaced, a separate Comparative Information Form is to be provided for each such policy.

3. In the disclosure of values, premiums shall be shown only if they increase the cash value or death benefits for the primary insured.

4. Any benefits for secondary insureds shall be shown on a supplementary exhibit.

5. Values will be shown for each year in which either an initial change in face value or premium payment occurs.

6. Values will be shown in the disclosure for the maximum duration policy guarantees permit. If this benefit extension requires that guaranteed policy options be utilized, the option to be used will be that *(those)* automatically utilized by the issuing insurer. However, if the policy application provides for applicant election, then the extension of benefits will employ the option actually elected by the applicant. Any option utilized for extension of benefits must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form.

7. The dividend option elected by an insured or applicant must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form. The dividend option elected by the insured or applicant must be employed in completing the disclosure of values.

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ACCELERATED BENEFITS RIDER DISCLOSURE STATEMENT

For use with: Term and Whole Life

BENEFITS PAID UNDER THIS RIDER MAY BE TAXABLE. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS.

This rider provides an accelerated payment of life insurance proceeds under conditions specified in this rider. It is not intended to provide health, nursing home or long-term care insurance. Cash values, loan values, if any, and death benefits will be reduced if you receive an accelerated benefit. Benefit payments may affect qualifications for entitlement payments.

DEFINITIONS

Eligible Proceeds means up to a total of $250,000 of the policy face amount.

Benefit Amount means the portion of the Eligible Proceeds you elect to receive, adjusted by a variety of factors including:

- expected future premiums;
- current dividends, if any; and
- interest rate. The maximum interest rate used will be no more than the greater of a) the current yield on 90-day treasury bills or b) the current maximum statutory adjustable policy loan interest rate.

We will also deduct a processing charge from the Benefit Amount. This charge will not exceed $100. We will tell you what the charge is when you request this rider's benefit.

Terminally Ill means having an expected life span of 12 months or less. You must provide us with a doctor's certification of the insured's life expectancy.

RIDER BENEFIT

Subject to rider conditions, you may request to receive the Benefit Amount while the insured is alive if the insured qualifies for the Terminal Illness Option. There are four types of rider conditions.

Conversion Conditions. These rider conditions concern which policies and riders you can convert to a Benefit Amount.

- You can combine all of your in-force life insurance coverage on the life of the insured from all policies and riders issued by Assurity.
- You cannot convert more than $250,000.

Election Conditions. These rider conditions tell you how to elect this rider's benefit.

- You must request the rider benefit in writing.
- You must send the request for the rider benefit to our administrative office.
- You must provide us with a physician's statement.

Voluntary Conditions. This rider's benefit is only available if you take it on your own policy. You cannot exercise this rider if you are required:

- by law to use this rider to pay creditors' claims; or
- by the government to use this rider to receive a government benefit.

General Conditions. You cannot elect this rider:

- during your policy's Contestable Period;
- within 2 years of your policy's final expiration date;
- if your policy is on extended term insurance; or
- if your policy is assigned or has an irrevocable beneficiary unless prior written acknowledgment to release is received by us.

Terminal Illness Options. This option lets you receive a Benefit Amount if the insured is Terminally Ill. If you do not want to receive the payment in a lump sum, you can be paid in 12 equal monthly payments. If you take 12 payments, we will pay interest of not less than 3 percent per year. If the insured dies before all 12 payments are made, we will pay the beneficiary the present value of future payments based on the monthly interest rate used to calculate the original payments.

EFFECT ON POLICY

Following the payment of the Benefit Amount, the policy will stay in force at a reduced amount. The reduction is the percentage of Eligible Proceeds used. For example, if you convert 25 percent of your policy's Eligible Proceeds, only 75 percent of the policy's face amount stays in force. The policy premium will be reduced to the premium that would apply had the policy been issued at the reduced amount. There will be no change in any policy or rider that was not part of the Eligible Proceeds. We will provide you with a revised policy schedule which reflects the reduction of all values applicable to the policy and all benefits the policy provides.

TERMINATION

This rider will terminate on the earlier of the following dates:

- the date we approve your written request to accelerate benefits; or
- the date your policy terminates for any reason.

Accelerated Benefit payments may adversely affect your eligibility for Medicaid or other government benefits or entitlements.

Your signature and the agent's signature below indicate that you received this **DISCLOSURE STATEMENT** at or before the time you applied for coverage.

Signature of Proposed Insured	*Printed Name of Proposed Insured*	/ / *Date (MM/DD/YYYY)*
Signature of Agent	*Printed Name of Agent*	/ / *Date (MM/DD/YYYY)*

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For use with: Term and Whole Life

BENEFITS PAID UNDER THIS RIDER MAY BE TAXABLE. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS.

This rider provides an accelerated payment of life insurance proceeds under conditions specified in this rider. It is not intended to provide health, nursing home or long-term care insurance. Cash values, loan values, if any, and death benefits will be reduced if you receive an accelerated benefit. Benefit payments may affect qualifications for entitlement payments.

DEFINITIONS

Eligible Proceeds means up to a total of $250,000 of the policy face amount.

Benefit Amount means the portion of the Eligible Proceeds you elect to receive, adjusted by a variety of factors including:

- expected future premiums;
- current dividends, if any; and
- interest rate. The maximum interest rate used will be no more than the greater of a) the current yield on 90-day treasury bills or b) the current maximum statutory adjustable policy loan interest rate.

We will also deduct a processing charge from the Benefit Amount. This charge will not exceed $100. We will tell you what the charge is when you request this rider's benefit.

Terminally Ill means having an expected life span of 12 months or less. You must provide us with a doctor's certification of the insured's life expectancy.

RIDER BENEFIT

Subject to rider conditions, you may request to receive the Benefit Amount while the insured is alive if the insured qualifies for the Terminal Illness Option. There are four types of rider conditions.

Conversion Conditions. These rider conditions concern which policies and riders you can convert to a Benefit Amount.

- You can combine all of your in-force life insurance coverage on the life of the insured from all policies and riders issued by Assurity.
- You cannot convert more than $250,000.

Election Conditions. These rider conditions tell you how to elect this rider's benefit.

- You must request the rider benefit in writing.
- You must send the request for the rider benefit to our administrative office.
- You must provide us with a physician's statement.

Voluntary Conditions. This rider's benefit is only available if you take it on your own policy. You cannot exercise this rider if you are required:

- by law to use this rider to pay creditors' claims; or
- by the government to use this rider to receive a government benefit.

General Conditions. You cannot elect this rider:

- during your policy's Contestable Period;
- within 2 years of your policy's final expiration date;
- if your policy is on extended term insurance; or
- if your policy is assigned or has an irrevocable beneficiary unless prior written acknowledgment to release is received by us.

Terminal Illness Options. This option lets you receive a Benefit Amount if the insured is Terminally Ill. If you do not want to receive the payment in a lump sum, you can be paid in 12 equal monthly payments. If you take 12 payments, we will pay interest of not less than 3 percent per year. If the insured dies before all 12 payments are made, we will pay the beneficiary the present value of future payments based on the monthly interest rate used to calculate the original payments.

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Following the payment of the Benefit Amount, the policy will stay in force at a reduced amount. The reduction is the percentage of Eligible Proceeds used. For example, if you convert 25 percent of your policy's Eligible Proceeds, only 75 percent of the policy's face amount stays in force. The policy premium will be reduced to the premium that would apply had the policy been issued at the reduced amount. There will be no change in any policy or rider that was not part of the Eligible Proceeds. We will provide you with a revised policy schedule which reflects the reduction of all values applicable to the policy and all benefits the policy provides.

TERMINATION

This rider will terminate on the earlier of the following dates:

- the date we approve your written request to accelerate benefits; or
- the date your policy terminates for any reason.

Accelerated Benefit payments may adversely affect your eligibility for Medicaid or other government benefits or entitlements.

Your signature and the agent's signature below indicate that you received this **DISCLOSURE STATEMENT** at or before the time you applied for coverage.

Signature of Proposed Insured	*Printed Name of Proposed Insured*	/ / *Date (MM/DD/YYYY)*
Signature of Agent	*Printed Name of Agent*	/ / *Date (MM/DD/YYYY)*

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Automatic PREMIUM PAYMENT

PLEASE PRINT WITH BLACK INK

Name of Proposed Insured _____
First *Middle* *Last*

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

The company's authority to debit from your account the first premium for this insurance does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Day of Withdrawal _____ Day ***cannot*** be the 29th, 30th or 31st. If no day is entered, the policy issue date will be used. Assurity will begin processing your bank draft on the day selected. Due to the bank's processing time, the actual day a withdrawal is posted to your account could be two or more days after the day selected.

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

☐ Do not draft initial premium: ☐ Payment enclosed or ☐ Payment collected on delivery

Type of Account: ☐ Checking ☐ Savings

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

_____ _____
Account Holder's Printed Name (if other than Proposed Insured/Owner) *Relationship (if other than Proposed Insured/Owner)*

_____ _____
Account Holder's Address (Street Address, P.O. Box, City, State, Zip+4) *Name of Authorized Officer (if any)*

_____ ___/___/___ (___) _____
Signature of Account Holder or Authorized Officer *Date (MM/DD/YYYY)* *Telephone No.*

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