Toll Free: **1-800-276-7619, Ext. 4264**
AssureLINK Address: **http://assurelink.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 **AssureLINK** 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 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 (402) 437-4591

Application for INSURANCE

PLEASE PRINT WITH 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.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type and 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

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

3. BENEFICIARIES *(Do not complete if applying for Reversionary Annuity or Disability Income coverage)*

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

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 MODE

☐ Annual ☐ Semi-Annual ☐ Quarterly

☐ Monthly *(Automatic Bank Withdrawal)* ☐ Monthly *(Credit Card)* ☐ List Bill

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)

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
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Application for INSURANCE

PLEASE PRINT WITH BLACK INK

5. PROPOSED JOINT 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.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type and 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

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 $

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 *(Policyowner is the Proposed Insured unless otherwise indicated)*

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

Social Security No.	Relationship to Insured

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

First	*Middle*	*Last*	
Contingent Owner's Name			Contingent Owner's Relationship to Insured

2. 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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			/ /	
			/ /	
☐ Testamentary Trust *(Will)*	N/A	N/A	N/A	
☐ Living Trust *(Please complete section below.)*	N/A	N/A	N/A	

Name of Living Trust _____

Date of Trust *(MM/DD/YYYY)* / / Tax ID No. of Trust _____

Name of Trustee(s) _____

Address of Trustee(s) _____

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? ☐ Yes ☐ No

   If YES, please explain: _____

2. During the past **5 years** or within the next **12 months** *(If YES to any of the following, please complete and return the Avocation Questionnaire)*:

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

   b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? ☐ 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 next **12 months**, does any Proposed Insured contemplate residence or travel outside of the United States? ☐ Yes ☐ No

   If YES, please explain: _____

4. 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:

   _____

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

   a. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined, 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: _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? ☐ Yes ☐ No

   If YES, please explain: _____

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

   a. Had their driver's license suspended or revoked, been convicted of or pleaded "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: _____

8. 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:

   _____

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

10. Does any Proposed Insured have other insurance coverage in force? ☐ Yes ☐ No
    If YES, please provide details below. If applying for life coverage, complete and return the appropriate State Replacement Form.

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

HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 2.

1. Has any Proposed Insured **ever** consulted with or been diagnosed, treated, hospitalized or prescribed medication by a 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, 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, 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 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. Has any Proposed Insured **ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)*, AIDS-related complex *(ARC)* or antibodies to human T-lymphotropic virus type III *(HTLV)*; or had a positive test for human immunodeficiency virus *(HIV)* antibodies? ☐ Yes ☐ No

4. 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

   _____

5. a. Has any Proposed Insured **ever** had any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No

   b. Is any Proposed Insured currently pregnant? ☐ Yes ☐ No

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

DETAILS: Enter complete details from questions #1-5 on page 2. 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:

Home Office Use Only

CRITICAL ILLNESS PRODUCT SECTION

Plan of Insurance: *(Check one)* ☐ Critical Illness ☐ Other *(Please specify)* ______________________

Base Amount $ ______________

ADDITIONAL BENEFITS *(If available)*

Check benefit(s) desired and indicate amount requested.

☐ Accidental Death Benefit Rider $ ____________ ☐ Children's Term Insurance Rider

☐ Waiver of Premium Rider ☐ Other *(Please specify)* ______________ $ ________

☐ Spouse Rider $ ____________ ☐ Other *(Please specify)* ______________ $ ________

☐ Additional Insured Rider(s) —Please complete the information below. If additional space is needed, attach a separate sheet of paper.

Additional Insured —Spouse

Name *First* *Middle* *Last*			☐ Male ☐ Female
Social Security No.	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /
Primary Employer		Height ft. in.	Weight lbs.

Additional Insured —Child

Name *First* *Middle* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No.	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured —Child

Name *First* *Middle* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No.	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured —Child

Name *First* *Middle* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No.	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured —Child

Name *First* *Middle* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No.	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured —Child

Name *First* *Middle* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No.	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured —Child

Name *First* *Middle* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No.	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

CRITICAL ILLNESS HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details in #7 below.

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

   a. Heart attack, stroke, elevated or abnormal cholesterol, angina, coronary heart disease, disease of the blood vessels or TIA *(transient ischemic attack)*? ☐ Yes ☐ No

   b. Thyroid disorder, hepatitis, hepatitis carrier, anemia, fatigue, disorder of the pancreas, any lupus or any other blood or glandular disorder? ☐ Yes ☐ No

   c. Polyp, mole, lump, other growth, breast disorder or abnormal mammogram, biopsy or abnormal prostate specific antigen *(PSA)* test? ☐ Yes ☐ No

2. Does any Proposed Insured regularly take any prescription medications? If YES, specify type and daily dosage in #7 below. ☐ Yes ☐ No

3. During the past **5 years**, has any Proposed Insured consulted any physician for any reason not detailed above? ☐ Yes ☐ No

4. Is any Proposed Insured aware of any symptoms or complaints regarding their health for which they have not yet consulted a physician? ☐ Yes ☐ No

5. Has any Proposed Insured been advised to have surgery, treatment or testing which has not been completed? ☐ Yes ☐ No

6. Has any Proposed Insured ever used marijuana or any illegal or addictive drugs? ☐ Yes ☐ No

7. **DETAILS:** Enter complete details from questions #1-6 below. If additional space is needed, attach a separate sheet of paper.

Question #/Letter	Name *(First, Middle Last)*	Relationship to Insured	Date of Condition *(MM/DD/YYYY)*	Health Condition & Details	Medical Care Provider's Name/Address/Phone
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
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			/ /		
			/ /		

8. Has any immediate family member *(whether living or dead)* of any Proposed Insured ever suffered from, or is currently suffering from: cancer, heart disease, stroke, kidney disease, diabetes, ALS *(amyotrophic lateral sclerosis 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 provide details below. If additional space is needed, attach a separate sheet of paper. ☐ Yes ☐ No

Name *(First, Middle, Last)*	Family Member/ Relationship	Diagnosis	Age at Time of Diagnosis

PRIMARY PHYSICIAN INFORMATION

Name _____
First *Middle* *Last*

Address _____
Street Address *Suite*

_____
City *State* *ZIP+4*

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

Date last consulted *(MM/DD/YYYY)* ____/____/____ 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 Conditional Receipt 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 Conditional Receipt or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

I acknowledge that I was provided an Outline of Coverage at the time this application for insurance was taken.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

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

_____ _____
Signature of Owner(s) (If other than Proposed Insured) *Signature of Beneficiary (If applying for Reversionary Annuity)*

_____ _____
Signature of Licensed Agent *Print Agent Name and Agent No.*

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

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

   b. Has a Conditional Receipt been given to the Policyowner? ☐ Yes ☐ No

   c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Fair Credit and MIB Notification? ☐ Yes ☐ No

2. a. Did you personally see all Proposed Insured(s) on 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

   _____

   d. Is the Proposed Insured(s) a citizen of the United States? If NO, provide a copy of a permanent visa—front and back. ☐ 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

   ☐ Abbreviated paramedical examination *(Tele-app only.)*

   ☐ Paramedical examination with Home Office *(H.O.)* specimen. *(Preferred classifications require blood profile, not dried blood spot.)*

   ☐ Medical exam by physician with H.O. specimen ☐ Chest X-ray ☐ Blood Profile ☐ Electrocardiogram ☐ Treadmill

   Name and address of examiner _____

   Date above items to be completed *(MM/DD/YYYY)* ____/____/____

4. 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.

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

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—signed authorization and voided check attached with the application.

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

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

LIST BILL

☐ Set up NEW list bill.

☐ 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

FOR WHOLE LIFE APPLICATION

All LifeScape® Whole Life cases require that either a signed illustration or a signed Illustration Disclosure Statement be submitted with the application.
The premiums for this application were quoted on the following underwriting classification:

☐ Preferred + ☐ Preferred ☐ Select NT ☐ Tobacco

FOR UNIVERSAL LIFE APPLICATION

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

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

FOR REVERSIONARY ANNUITY APPLICATION

All cases require that either a signed illustration or a signed Illustration Disclosure Statement 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.*	*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

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
1526 K STREET, P.O. BOX 82533, LINCOLN, NEBRASKA 68501-2533
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 X4264

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 X4264

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

Accident or Sickness Insurance
REPLACEMENT NOTICE

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

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

Accident or Sickness Insurance
REPLACEMENT NOTICE

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1. Health conditions that 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.

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

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

Automatic PREMIUM PAYMENT

Name of Proposed Insured _____ Date Signed ____/____/____
First Middle Last *(MM/DD/YYYY)*

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

Name of Account Holder or Authorized Officer _____

☐ Initial and recurring premiums ☐ Recurring premiums only

If "Initial and recurring premiums" is marked, 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.

Type of Account: ☐ Checking ☐ Savings

Date of Withdrawal _____ Date ***cannot*** be the 29th, 30th or 31st. If no date is entered, the policy issue date will be used.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account listed below for premiums as selected above. 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 if any premium is not honored, my policy may lapse and require evidence of insurability, according to the terms of my policy.

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

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

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

CREDIT CARD AUTHORIZATION

Name of Account Holder or Authorized Officer _____

☐ Initial premium only ☐ Recurring premiums only ☐ Initial and recurring premiums

If "Initial premium only" or "Initial and recurring premiums" is marked, the company's authority to charge the first premium for this insurance to your credit card does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Type of Card: ☐ MasterCard ☐ Visa ☐ Discover

Date of Charge: ☐ 1st ☐ 5th ☐ 10th ☐ 15th ☐ 20th ☐ 25th
If no date is selected, recurring charges will occur on the option date immediately prior to the policy issue date.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate charges to my credit card listed below for premiums as selected above. 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 charges to my credit card. I further understand that if the date of the withdrawal is after the policy issue date and if any premium is not honored, my policy may lapse and require evidence of insurability, according to the terms of my policy.

_____ _____ ____/____
Name as it appears on Card (Please print) *Card/Account No.* *Expiration Date (MM/YYYY)*

Credit card billing address _____
Street Address P.O. Box City State Zip+4

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

ASSURITY LIFE INSURANCE COMPANY
1526 K Street, P.O. Box 82553
Lincoln, Nebraska 68501-2533

OUTLINE OF COVERAGE
CRITICAL ILLNESS INSURANCE POLICY
FORM NO. CI 007

"We**"** are **Assurity Life Insurance Company**, the company providing this Outline of Coverage. The address is P.O. Box 82533, Lincoln, Nebraska, 68501-2533. We are required to give You the following information:

- **THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED. CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS**.

- **CAPITALIZED WORDS ARE USED AS DEFINED IN THE POLICY.**

- **RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS**.

- **READ YOUR POLICY CAREFULLY**. This Outline of Coverage gives a summary of the important features of Your Policy. This is not the insurance contract. Only the actual Policy provisions will control. The Policy details both Your rights and obligations and Our rights and obligations as Your insurance company.

- **CRITICAL ILLNESS COVERAGE** is designed to provide You with a lump sum payment if You are diagnosed for the first time ever with one of the specified conditions or undergo for the first time ever one of the specified procedures named in the Policy. A limited benefit is paid for cancer in situ, coronary bypass and angioplasty. No Benefits are paid for basic hospital, medical-surgical, or major medical expenses. The following pages give a summary of the benefits, limitations, conditions and costs of Your Policy.

THIS IS A LIMITED BENEFIT POLICY!

POLICY BENEFITS

While Your Policy is in force, We will pay You the Benefit Amount if You receive a First Ever Diagnosis or Procedure for one of the following Specified Covered Conditions:

Critical Illness Covered Condition	Percentage of Maximum Benefit Payable
a) Invasive Cancer	100%
b) Heart Attack	100%
c) Stroke	100%
d) Accidental Loss of Speech	100%
e)Advanced Alzheimer's Disease	100%
f) Aortic Surgery	100%
g) Benign Brain Tumor	100%
h) Blindness	100%
i) Coma	100%
j) Deafness	100%
k) End-Stage Renal Failure	100%
l) Heart Valve Replacement/Repair Surgery	100%
m) Loss of Limbs	100%
n) Major Burns	100%
o) Major Organ Transplant	100%
p) Motor Neuron Disease	100%
q) Occupational HIV Infection	100%
r) Paralysis	100%
s) Angioplasty	25% up to a maximum of $25,000
t) Cancer in Situ	25% up to a maximum of $25,000
u) Coronary Bypass Surgery	25% up to a maximum of $25,000

and;

If a portion of the Maximum Benefit Amount is paid under the Policy or certain attached Riders (if applicable), the Maximum Benefit Amount will be reduced by the amount paid, and the premium will be adjusted accordingly. The Owner will be notified of the new Maximum Benefit Amount and new Premium. In no event will the payment(s) for any Critical Illness Insured Condition(s) exceed the Maximum Benefit Amount then in force.

Reduced Benefit After Age 65. Beginning in the Policy year immediately following the Insured's 65th birthday or five years from the Policy Issue Date, which ever is later, the Maximum Benefit Amount then in force will be automatically reduced by 50%. This will be the Maximum Benefit Amount available for the remaining years the Policy is in force.

Definitions of each Specified Covered Condition or Procedure are found in Your Policy.

LIMITATIONS

- The Benefit Amount for Coronary Bypass Surgery and Cancer in Situ is 25% of the Maximum Benefit Amount. The Benefit Amount for Angioplasty is 25% of the Maximum Benefit Amount.
- For Invasive Cancer, a reduced benefit equal to 10% of the Maximum Benefit Amount will be paid if the First Ever Diagnosis is made anytime within 90 days following the Issue Date of the Policy. For Cancer in Situ, a reduced benefit equal to 2.5% of the Maximum Benefit Amount will be paid if the First Ever Diagnosis is made anytime within 90 days following the Issue Date of the Policy.

EXCLUSIONS

We will not pay a Benefit Amount for a Specified Covered Condition or Procedure resulting from

- participating in or attempting to commit a felony;
- engaging in an illegal occupation;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide, whether sane or insane; or
- involvement in any period of armed conflict, whether declared or not.

PREMIUMS

The first Premium is due on the Date of issue. Premiums due after the first Premium are Renewal Premiums. Renewal Premiums are paid at the Premium payment interval. You can change this. The date the next Renewal Premium is due is the Due Date. Renewal Premiums are paid before the Due Date.

You have a Grace Period to pay Renewal Premium payments. The Grace Period starts on the Due Date and ends 31 days later. During the Grace Period, Your Policy stays in force. If You do not pay the Renewal Premium by the end of the Grace Period, Your Policy will end for non-payment of Premium.

If Your Policy ends because You did not pay a Renewal Premium, You can ask to have the Policy put back in force. This is called Reinstatement. You must ask for Reinstatement within 2 years of the lapse of Your Policy. We will decide if the Policy is put back in force. The Reinstated Policy will only pay a Benefit Amount for First Ever Diagnosis of Covered Specified Diseases or Procedures that happen after the Policy has been put back in force.

RENEWABILITY

This Policy is Guaranteed Renewable for life. That means We cannot cancel or change Your Policy as long as You pay Premiums. We can change the Premium rates. If We do this, We can only do it to all Policies in Your class, with Your state's approval.

RIGHT TO CANCEL

You may cancel the Policy within 30 days of receiving it. Return the Policy to Assurity's Home Office or Your Assurity sales agent. As soon as You deliver or mail the Policy to Us, it is treated as if it was never issued. We will give back Your Premium payment. After the first 30 days, You may cancel this Policy at any time by telling Us in writing. The Policy will be cancelled on the date We receive Your written notice or the date You tell Us in Your notice. We will give back any unearned Premium.

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED. CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.