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

Ohio Application for Disability Income Insurance

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

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

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

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

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

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

Disability Income (Form A-D109): CA, FL
Simplified Critical Illness (Form CI 005): AR, CO, FL, ID, ME, MN, MT, NH, NC, ND, OK, PA, UT, WV
Critical Illness (Form CI 007): AR, ID, ME, MT, NC, ND, OK, PA, UT, WV

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

✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state coinciding with the application used.**

✓ Print the application in black ink for faxing and photocopying purposes.

✓ Please verify that all questions on the application are answered. Obtain all required signatures.

✓ Have the Proposed Insured initial any changes. (Corrections with white correction fluid/tape are not acceptable.)

✓ Comply with all state regulations
1. NAIC Model Illustration or disclosure statement must accompany any whole life application.
2. Complete all other pertinent and applicable forms padded together in this application.

If faxing an application directly to the Home Office, fax to (402) 437-4591.
If emailing an application directly to the Home Office, email to appsubmit@assurity.com.

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

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

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

Insurance Application to Assurity Life Insurance Company

PART 1 – General Section – Any person who knowingly and with intent to injure, defraud, or deceive an insurance company, submits an application or files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

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

1. A. Full First Name (Please Print) Middle Initial Last Name			B. Social Security #	C. Sex ☐ M ☐ F
D. Date of Birth Mo. Day Year / /	E. Age Nearest birthday	F. Height Weight _____ _____	G. Weight change in past year _____ lbs. ☐ loss ☐ gain	H. Birth State

2. A. Residence: Street and No. City State Zip Code

B. Proposed Insured's home phone number Best time to call Proposed Insured

3. A. Occupation and duties (including those pertaining to any part-time occupation) Occupation: Duties:	B. Employer and address _____ _____ _____ _____ _____ _____ C. How long employed?	D. Gross average Monthly income (if not self-employed) If self-employed, net monthly income:

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

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

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

Full Name	Relationship	Birthdate	Age	Height	Weight lbs.	Residing w/ Insured	Name/Address of Physician
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

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

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

15. Answer only if applying for the Catastrophic rider on your Disability Income application.
Have you ever needed assistance or personal supervision to perform any Activities of Daily Living (toileting, transferring, continence, eating, bathing, or dressing)? If "yes", please explain below in question #16. ☐ Yes ☐ No

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

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

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

18. Family History: Has any of your immediate family members (parents, brothers, or sisters) died from cancer, diabetes or cardiovascular disease prior to age 60?…… ☐ Yes ☐ No
If "yes," identify family member, disorder, and age at death below:

_____

_____

19. A. Has any person to be insured had any disorder of any genital or reproductive organ; or a miscarriage, stillbirth or Cesarean section?…… ☐ Yes ☐ No
B. Is any person to be insured now pregnant? If "yes," give date child is expected: _____ ☐ Yes ☐ No

PART 1 – DISABILITY SECTION

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

Company or Source	Type 1-5 (above)	Monthly Amount	Elimination Period	Benefit Period	Coordinates with Social Security?	Employer Paid?
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N

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

OPTIONAL BENEFITS/RIDERS

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

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

BUSINESS OVERHEAD EXPENSE DISABILITY

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

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

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

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

I AGREE THAT

A. I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree that this application (Part 1—General Section, pages 1 and 2 and Part 1—Disability Section, and Answers Made to the Medical Examiner if required) shall form a part of the policy if attached thereto.

B. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Conditional Receipt delivered by the Company's agent in exchange for such payment.

C. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless the application is approved by the Company at its Home Office, such policy issued and delivered to Proposed Insured/Owner, and such first full premium paid during the Proposed Insured's lifetime and continued good health, and when such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.

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

Signed at _____ this_____ day of _____ , Year _____ .

Witnessed by _____ _____
Licensed Resident Agent Signature of Proposed Insured

Agency No _____

Field Underwriter's Statement

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

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

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

   _____ _____ _____
   Soliciting Agent Printed Name — Agent Business Phone # — Agent Fax #

   Agent E-mail Address: _____
7. Special requests, remarks and instructions:
8. **Referrals** Name: _____
   Name: _____

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

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

Name of Company _____
_____

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

APP-01-US (OH)

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

UNDERWRITING AUTHORIZATION AND ELECTION

Name of Proposed Insured ("Applicant")_____

I, on behalf of myself or the person named above ("Applicant"), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau ("MIB"), consumer reporting agency, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Assurity"), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (except as may be related directly or indirectly to sexual orientation), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.
- Information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Applicant has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance (including additional coverage to an existing policy) and/or eligibility for benefits under a policy. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information.

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

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

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

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under the law.

_____

Signature of Proposed Insured or Personal Representative Date

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

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

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

UNDERWRITING AUTHORIZATION AND ELECTION

Name of Proposed Insured ("Applicant")_____

I, on behalf of myself or the person named above ("Applicant"), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau ("MIB"), consumer reporting agency, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Assurity"), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Psychotherapy notes.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Applicant has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire psychotherapy notes as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance (including additional coverage to an existing policy) and/or eligibility for benefits under a policy. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information.

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

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

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

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under the law.

_____

Signature of Proposed Insured or Personal Representative Date

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

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

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, ("We", "Us", "Our" and "Assurity") and by Your Assurity agent.

Obtaining information about You …

In the course of properly underwriting and administering Your insurance coverage, We rely primarily on the information You provide in Your application. Sometimes 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.

The types and sources of information We may use …

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 We may require.

Information We obtain is treated confidentially …

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 which 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.

Your right to access personal information …

Generally, 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 need more information …

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. Please let Us know whether You are applying for group or individual coverage. If You are already an Assurity Life Insurance Company policyholder or insured, Your group and certificate number or individual policy number will help Us in assisting You.

Company's Address

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

MIB'S Address

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

Conditional Receipt

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

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

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

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

Conditional Receipt

Assurity Life Insurance Company • Lincoln, Nebraska

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

1. The sum of $_____is received of _____by Assurity Life Insurance Company ("The Company") in payment of the full initial premium on insurance applied for on this date. Payment is accepted subject to the terms and limitations of this Conditional Receipt ("Receipt"). It is expressly understood and agreed that unless all conditions set forth in this Receipt are satisfied, or that unless the coverage applied for is issued within 60 days of the date of application, no insurance shall ever take effect. In such case, the Company's only liability and obligation is to promptly refund the premium payment received.

2. If, on the applicable date, the Proposed Insured was acceptable for the plan and amount of insurance applied for, without modification, under Assurity's rules, limits and standards of insurability, coverage will be effective the later of i) the date of application, or ii) the date any medical examination of the Proposed Insured is completed, if required by the Company. Insurance will be issued at Assurity's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.

3a. Assurity Life Insurance Company has NO liability for life insurance coverage if the answers to the health questions on the application indicate any significant health problems. Otherwise, the Company's total life insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that for which this Receipt is given) shall not exceed $500,000 if all application health questions are answered, and shall not exceed $100,000 if no application health questions are answered.

b. Assurity Life Insurance Company has NO liability for health insurance coverage and this Receipt is void for any insurance if any health questions on the application have not been answered and no medical examination is required of the Proposed Insured. Otherwise, the Company's total health insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that which this Receipt is given) shall not exceed $2,500 per month.

These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.

4. This Receipt must not be detached and used unless the full amount of the first premium is paid on the date of the application. Payment cannot be accepted with the application if any person proposed for coverage has been treated for or had any known heart trouble, stroke or cancer within the past twelve months. This Receipt is void if exchanged for any check or draft that is not honored upon first presentation for collection through usual banking facilities.

Dated: _____ Agent: _____

ASSURITY LIFE INSURANCE COMPANY
1526 K Street - Box 82533
Lincoln, Nebraska 68501-2533
Telephone Toll Free (800) 276-7619, Ext. 4264

OHIO INFORMED CONSENT TO HIV ANTIBODY TEST

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

The HIV Virus

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to the HIV virus are found in the blood and other bodily fluids of most people with AIDS and AIDS-Related Complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (a single needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure, which is extremely reliable. The testing will be performed by a licensed laboratory.

Pre-Testing Consideration

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

Disclosure of Test Results

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal, you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who requires the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies, which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

Test Results

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with the HIV virus and infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

Other Sources of Information

For more information about AIDS you may call the Ohio AIDS Hotline at 1-800-332-2437.

Consent for HIV Testing

I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This CONSENT is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this 90 (ninety) day period.

Notification of Positive Test Result

In the event of a positive test result:

☐ Send the results to me at:

_____

(Address)

☐ I authorize Assurity to send the result to another person:

_____

(Name)

_____

(Address)

☐ I authorize Assurity to send the result to the following physician or health care provider:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Authorization:

_____

Printed Signature of Applicant

_____ _____

Signature of Applicant Date

_____ _____

Signature of Legal Guardian, if any Date

_____ _____

Signature of Agent Date

HIV-OH-99 (Rev. 8/00) **Signed form to be returned to Home Office**
Applicant to receive a copy of signed form at time the application is taken

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Automatic Bank Withdrawal

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

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account.

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

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

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

Type of account: ☐ Checking ☐ Savings

Signature of Account Holder	Date Signed	Telephone Number
_____	_____	_____

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

ATTACH VOIDED CHECK HERE