

## Application for Disability Insurance

**This application does not include the Life Section, Page 3 and Page 6.**



1526 K Street  
PO Box 82533  
Lincoln, NE 68501-2533

Toll Free # 1-800-276-7619

Intranet Address:  
<http://info.assurity.com>

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

To enable us to process your application quicker, please review the following guidelines. If you decide to write a Life application in combination with this Disability application, please complete the Life Page 3, which can be obtained from the Intranet or from a Life application.

- To comply with state regulations and protect your interest, you must be ***properly licensed and appointed by Assurity in the Proposed Insured's (or Owner's\*) "State of Residence"***.
- Please ***use the appropriate application for the state in which the Proposed Insured (or Owner\*) resides.*** Applications and state forms may be found on our Intranet.
- ***Print application in black ink*** for faxing and photoing purposes.
- Please ***verify that all questions on the application are answered.***
- ***Use Age Nearest birthdate*** when preparing illustrations for calculating insurance premiums.
- ***Obtain all required signatures.***
- ***Have the Proposed Insured initial any changes.*** (Corrections with white correction fluid are not acceptable.)
- ***Review the Conditional Receipt for collection limits.*** (If Proposed Insured has a history of heart trouble, stroke, or cancer, do not collect the initial premium.)
- ***Please check the Intranet for an update on regulations and forms required for each state. HIV forms and Replacement forms are available for printing from our Intranet.***
- ***If your state does not require a replacement form*** for Internal or External replacement, ***please complete the IMSA Replacement form (for Life Insurance only).***
- Please ***mail applications to the address indicated on this cover sheet. (If faxing applications, please fax the applications to the following fax number: (402) 437-4591***

# Insurance Application to Assurity Life Insurance

**PART 1 - General Section – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

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

1.(A) Full First Name (Please Print) Middle Initial Last Name	(B) Social Security # _____ - _____ - _____	(C) Sex <input type="checkbox"/> M <input type="checkbox"/> F
(D) Date of Birth Mo. Day Year / /	(E) Age nearest birthday	(F) Height Weight
(G) Weight change in past year _____ lbs. <input type="checkbox"/> loss <input type="checkbox"/> gain		(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 (include those pertaining to any part-time occupation)	(B) Employer and address  (C) How long employed?	(D) Gross average monthly income (if not self-employed)  If self-employed, net monthly income:
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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. If State form not required, complete the IMSA-99 form)**
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 I - General Section (Cont.)** If medical exam required due to age and/or amount, you may omit answering questions 14 - 18 on Proposed Insured.

13. Names of dependent children (who haven't reached their 19<sup>th</sup> birthday) proposed for Children's Term Insurance Rider.

**(Note: Please complete 14-16 for any children to be covered.)**

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

14. Have any persons to be covered ever been treated for, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following? If "yes," circle condition(s) and complete #15 below.

- A. Dizziness, fainting spells, epilepsy, depression, anxiety, mental disorder, or any disease or disorder of the brain or nervous system?.....  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. Any immune deficiency disorder, AIDS or the AIDS Related Complex (ARC)? .....  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. If any questions in 14 are answered "yes," indicate the question number and give complete details.

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

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

17. 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:

\_\_\_\_\_

18. 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? .....  Yes  No  
 If "yes," give date child is expected: \_\_\_\_\_

# Part I – Disability Section

21. 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, and 4) Business Overhead Expense. If "None," so state.**

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

22. 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 \_\_\_\_\_

23. Who should receive Survivor Benefits? Name \_\_\_\_\_ Relationship \_\_\_\_\_

### BUSINESS OVERHEAD EXPENSE DISABILITY

24. Monthly Income Base Amount \$ \_\_\_\_\_ Occupation Class \_\_\_\_\_  Tobacco  Non-Tobacco

Elimination Period  30  60  90 Days Benefit Period  12 months  24 months

25. Average monthly expenses currently incurred, for which Proposed Insured is liable.

Employees' 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	\$ _____		\$ _____
		<b>TOTAL MONTHLY EXPENSES</b>	<b>\$ _____</b>

26. How shall premiums be payable?  Annually  Semi-annually  Quarterly  PAC  Other \_\_\_\_\_

### I AGREE THAT

- 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 I – General Section, pages 1 and 2 and Part I – Disability Section, page 4; and Part II – Medical if required) shall form a part of the policy if attached thereto.
- 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.
- 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.
- 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 \_\_\_\_\_ X \_\_\_\_\_  
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," please explain in #7.
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.

\_\_\_\_\_ Agent Fax # \_\_\_\_\_

Soliciting Agent Printed Name

Agent Business Phone #

The above code number is for  Assurity Life Insurance Co.

7. Special requests, remarks and instructions:

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

8. **Referrals** Name: \_\_\_\_\_  
 Name: \_\_\_\_\_

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 \$ \_\_\_\_\_

## UNDERWRITING AUTHORIZATION AND ELECTION

I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, the MIB, Inc. (Medical Information Bureau), consumer reporting agency or employer to disclose to Assurity Life Insurance and its Parent Company, its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB, Inc.) available information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition or treatment and information pertaining to mode of living, occupation, finances, avocations and other characteristics to evaluate applications for insurance of the undersigned and/or

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*(identify relationship of such person to the undersigned; e.g., minor child)*

- I understand the information so acquired will be used to determine eligibility for insurance (including additional coverage to an existing policy.)
- I understand and agree that the information obtained by use of this authorization and found on my application(s) may be released by Assurity Life Insurance and/or its reinsurers to their consulting physicians, their attorneys and the MIB, Inc.
- I elect to be interviewed if an investigative consumer report is prepared in connection with my application(s) for insurance.
- I acknowledge receipt of Assurity Life Insurance Company's Description of Information practices which includes the notices required by the Fair Credit Reporting Act and MIB, Inc.
  - (1) A photographic copy of this authorization shall be as valid as the original.
  - (2) This authorization will be valid from the date signed for a period of twenty-four months.
  - (3) I understand that I have the right to receive a copy of this authorization.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_.

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Signature of Proposed Insured  
Authorized Representative

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Signature of the Spouse  
(if to be Insured)

## **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 it may relate 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. 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  
P.O. Box 82533  
Lincoln, Nebraska 68501-2533  
Toll-Free No. (800) 869-0355

#### **MIB’s Address**

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

**Assurity Life Insurance Company**  
1526 K Street • Box 82533  
Lincoln, Nebraska 68501-2533  
Telephone Toll-Free: (800) 869-0355

## **Notice of Investigative Consumer Report**

Required by the  
**Fair Credit Reporting Act**

We appreciate your application for insurance and intend to process it as speedily as possible so that you can know whether it has been approved. As is customary in the business world, and as part of our normal underwriting procedure, an investigative consumer report may be obtained. These reports typically include information on a Proposed Insured's character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates. Upon written request to the Underwriting Department at the Company's address above, further information as to the nature and scope of the report will be furnished you.

## **Notice of Acquisition and Disclosure of Confidential Information**

Required by the  
**Medical Information Bureau (MIB)**

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

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

Assurity Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

# Conditional Receipt

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

The following Conditional Receipt is issued by 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 does not exceed \$250,000. This \$250,000 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 Benefit plus SIDR 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 the 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 the Company'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 the Company's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.
  
- 3a. The 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 \$250,000 if all application health questions are answered, and shall not exceed \$100,000 if no application health questions are answered.
  
- b. The 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 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  
PO BOX 82533 • LINCOLN NE 68501-2533  
TOLL FREE 800-627-7212**

## **Notice to Applicant Regarding Replacement of Accident and Health Insurance**

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health 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 factors which may affect the insurance protection available to you under the new policy. In particular, study the comparison statement which your agent is required to furnish you upon taking your application.

1. Health conditions which you may presently have, (pre-existing conditions) 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 an application may provide a basis for the company to deny any future claims. 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:

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Date

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Applicant's Signature

# Automatic Bank Withdrawal

———— Saves you **TIME** and **MONEY!** ————

**Automatic Bank Withdrawal** conveniently pays your monthly 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 with a voided check or deposit slip.** Remember to indicate the date of withdrawal that would be most convenient for you.

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## Assurity Life Insurance Company

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 you receive such notice, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account.

\_\_\_\_\_  
Policy Number(s)

\_\_\_\_\_  
Date of Withdrawal  
(cannot be the 29th, 30th or 31st)

\_\_\_\_\_  
Signature of Account Holder

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

**ATTACH VOIDED CHECK  
or DEPOSIT SLIP HERE**