

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.)
- **Comply with all state regulations regarding:**
 1. HIV Consent form
 2. Replacement of existing insurance:
Another company's policy - State Replacement form

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

I hereby apply for insurance with Assurity Life Insurance Co. 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 <small>(Please Print)</small> 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 <small>(include those pertaining to any part-time occupation)</small>	(B) Employer and address (C) How long employed?	(D) Gross average monthly income <small>(if not self-employed)</small> 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 have not reached their 19th 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	\$ _____		\$ _____
		TOTAL MONTHLY EXPENSES	\$ _____

26. 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 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.**
- 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 _____ **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 Business Phone # Agent Fax #

Soliciting Agent Printed Name

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 \$ _____

Authorization for the Release of Medical Information

I authorize any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau ("MIB"), consumer reporting agency or employer to disclose to Assurity Life Insurance Company and its Parent Company ("the 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) 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 (except as may be related directly or indirectly to sexual orientation), occupation, finances, avocations and other characteristics to evaluate applications for insurance of the undersigned and/or:

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

I understand 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 an existing policy. I also understand the information obtained by use of this authorization may be released by the Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the undersigned and/or any other person(s) named in this authorization have policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

This authorization is valid for twelve (12) months. A photographic copy of this authorization is as valid as the original. I understand that I have the right to receive a copy of this authorization and I acknowledge receipt of the notices required by the Fair Credit Reporting Act and MIB.

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 law.

Dated this _____ day of _____, Year _____

(Signature of Witness)

(Signature of Proposed Insured)

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 or its Parent 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 and its Parent 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 have 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: _____

PENNSYLVANIA HIV ANTIBODY TEST INFORMATION FORM

ABOUT AIDS. Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25-50% chance of developing AIDS over the next 10 years.

ABOUT THE TEST. Please read the important information below *before* you consent to testing:

Purpose: This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

Positive Test Results: If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

Accuracy: An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

- a. **False Positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.
- b. **False Negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

Side Effects: A positive test result may cause you significant anxiety. A positive test result may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

Disclosure of Results: You will be notified in writing if your application for insurance is denied. Specific results of positive HIV tests will be communicated only to a physician named by you. You should contact your physician for more information about the results of your HIV test.

Confidentiality: Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

Prevention: Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

Information and Pre-Test Counseling: You may wish to consider counseling, at your expense, before being tested. Additional information about AIDS and HIV test counseling can be obtained by contacting your physician, your county health department, the Pennsylvania Health Department, or any of the organizations listed on the back of this information form.

PENNSYLVANIA AIDS COUNSELING RESOURCES

Pennsylvania Health Department
(717) 783-0479

Pittsburgh AIDS Task Force
141 South Highland Avenue
Pittsburgh, PA 15206
(412) 363-2437

Philadelphia Community Health Alternatives
1642 Pine Street
Philadelphia, PA 19103
(215) 735-1911

Congresso-de Latinos Unitas, Inc.
Programa Esturzo
704 West Girard Avenue
Philadelphia, PA 19103
(215) 625-0550

BEBASHI
5205 North Broad Street
Philadelphia, PA 19141
(215) 546-4140

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

PENNSYLVANIA INFORMED CONSENT TO HIV ANTIBODY TEST

I authorize Assurity Life Insurance Company Company (“Assurity”) and its designated medical facilities to draw samples of my blood or other bodily fluids for the purpose of laboratory testing to provide applicable medical information about my insurability. These tests may include but are not limited to tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law), immune disorders or the presence of medications, drugs, nicotine or other metabolites. The tests will be done by an extremely reliable medically accepted procedure.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory according to the following medical protocol:

1. An initial ELISA blood or other bodily fluid test will be done.
 - a. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.
 - b. If the initial ELISA blood or other bodily fluid test is negative, a negative finding will be reported to Assurity.
2. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.
 - a. If the second ELISA blood or other bodily fluid test is also positive, a Western Blot blood or other bodily fluid test will be performed to confirm the positive results of the two ELISA blood or other bodily fluid tests.
 - b. If the second ELISA blood or other bodily fluid test is negative, a third ELISA blood or other bodily fluid test will be performed. If that ELISA blood or other bodily fluid test is positive, a Western Blot blood or other bodily fluid test will be performed to confirm the previous positive results. If the third ELISA blood or other bodily fluid test is negative, a negative test result will be reported to Assurity.
3. Only if at least two ELISA blood or other bodily fluid tests and a Western Blot blood or other bodily fluid test are all positive will the result be reported as positive. All other results will be reported as negative to Assurity.

Without a court order or written authorization from me, these results will be made known only to Assurity and/or its reinsurers involved in the underwriting process. In addition, Assurity may make a brief report to MIB in a manner described in the information I received as part of the application process. Assurity will only report to MIB that positive results were obtained from a blood or other bodily fluid test. Assurity will not report what tests were performed or that the positive result was for HIV antibodies. These organizations will be the only ones maintaining this information in any type of file except as required by law.

Assurity will provide results of all tests to a physician of my choice. Positive test results to the HIV Antibody Test will be disclosed only to my physician or my local Health Department at the following address:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

This authorization will be valid for 90 days from the date below. 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.

Dated at _____ on _____
City and State Month, Date, and Year

Signature of Proposed Insured (or Parent/Guardian)

Signature of Witness (Agent' Signature)

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

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application or other 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 .Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. 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.

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. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
3. 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 is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
4. 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 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 be properly recorded.

The above “Notice to Applicant” was delivered to me on: _____

Date

Signature of Applicant

I certify that this form was given to and completed by _____

Name of Applicant - please print or type

prior to taking an application and that I am leaving a signed copy for the Applicant.

Signature of Agent

Date

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.

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**