



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

Missouri 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.

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

- ✓ The application should coincide with the **state in which the policy Owner resides**. (For Disability applications, the Proposed Insured and the policy Owner must be the same person.) State specific applications and state forms can be found on AssureLINK.
- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity in the **state coinciding with the application used**.
- ✓ Print the application in black ink for faxing and photocopying purposes.
- ✓ Please verify that all questions on the application are answered. Obtain all required signatures.
- ✓ Have the Proposed Insured initial any changes. (Corrections with white correction fluid/tape are not acceptable.)
- ✓ Comply with all state regulations
 1. NAIC Model Illustration or disclosure statement must accompany any whole life application.
 2. Complete all other pertinent and applicable forms padded together in this application.

If faxing an application directly to the Home Office, fax to (877) 864-6630.

- ✓ If mailing directly to the Home Office, address to:
Assurity Life Insurance Company
Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

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

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy, MO 65734
service@insspecial.com
800-789-0182

Disability Income

HIPAA Compliant

Missouri

**ASSURITY LIFE INSURANCE COMPANY**Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630**Application for
DISABILITY INCOME INSURANCE****PLEASE PRINT WITH BLACK INK**

1. PROPOSED INSURED									
Legal Name <small>First Middle Last</small>						Date of Birth <small>(MM/DD/YYYY)</small>			
Social Security No.			<input type="checkbox"/> Male <input type="checkbox"/> Female		E-mail			Age	
Home Address <small>Street Address City State ZIP+4</small>									
Personal Phone No. ()				Birth State/Country			Height ft. in.		Weight lbs.
Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If YES, please list type: amount per day: last date of use (MM/DD/YYYY) / /									
Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident (green card) status? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If the Proposed Insured has permanent resident status, please list permanent resident (green card) number.									
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number.									
Is the Proposed Insured currently working at least 30 hours per week in primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of employment <small>Years Months</small> /									
Primary Employer			Employer's Address <small>Street Address City State ZIP+4</small>						
Full-time Employment <small>Occupation Duties</small>					Part-time Employment <small>Occupation Duties</small>				
Gross monthly income \$					If self-employed, net monthly income \$				
2. BENEFICIARIES									
Primary Beneficiary Name (First, Middle, Last)				Relationship	Soc. Sec. No.		Date of Birth		Share %
							/ /		
							/ /		
							/ /		
							/ /		
Contingent Beneficiary Name (First, Middle, Last)				Relationship	Soc. Sec. No.		Date of Birth		Share %
							/ /		
							/ /		
							/ /		
							/ /		
3. PREMIUM PAYMENT									
Please indicate preference for payment type and billing frequency below.									
Type					Frequency				
<input type="checkbox"/> Direct Billing		<input type="checkbox"/> Automatic Credit Card			<input type="checkbox"/> Annual		<input type="checkbox"/> Semi-Annual		<input type="checkbox"/> Quarterly
<input type="checkbox"/> List Billing (employer)		<input type="checkbox"/> Automatic Bank Withdrawal			<input type="checkbox"/> Monthly (not available with Direct Billing)				
Payor Name <small>First Middle Last</small>			Billing Address	Street Address			City	State	ZIP+4
Secondary Payor Info. <small>First Middle Last</small>			Billing Address	Street Address			City	State	ZIP+4



GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? Yes No
 If YES, please explain _____

2. During the past 5 years or within the next 12 months:
 a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured contemplating flying as a pilot, crew member or student? Yes No
 b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? Yes No
 If YES, check all that apply: Skin/Scuba Diving Bungee Jumping Skydiving/Parachuting/Hang Gliding
 Motor-powered Racing Boxing Rodeo Professional, Semi-professional or Club Sports
 Cave Exploration Mountain/Rock/Ice Climbing Hot Air Ballooning

3. During the next 12 months, does any Proposed Insured contemplate residence or travel outside of the United States? Yes No
 If YES, please explain _____

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

5. During the past 5 years, has any Proposed Insured:
 a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? Yes No
 If YES, please explain _____
 b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? Yes No
 If YES, please explain _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? Yes No
 If YES, please explain _____

7. During the past 5 years, has any Proposed Insured:
 a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence (DUI/DWI), or had more than 3 moving violations? Yes No
 If YES, please explain _____
 b. Been convicted of a felony? Yes No
 If YES, please explain _____

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

9. a. Is other insurance coverage in force for any Proposed Insured? Yes No
 If YES, please provide details below.
 b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? Yes No

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



HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 4.

1. During the past 10 years, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
 - a. Heart disorder, including a heart attack (*myocardial infarction*), angina, irregular heartbeat or abnormal heart rhythm (*arrhythmia*), chest pain, hypertension (*high blood pressure*), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (*TIA or mini-stroke*), or rheumatic fever? Yes No
 - b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease (*other than kidney stones*), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, thyroid, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? Yes No
 - c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? Yes No
 - d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (*including Down's syndrome*), multiple sclerosis (*MS*), muscular dystrophy (*MD*), Parkinson's disease, amyotrophic lateral sclerosis (*ALS*), any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy? Yes No
 - e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (*COPD*), shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (*lupus or scleroderma*)? Yes No
 - f. Dizziness, headaches, migraines, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? Yes No
 - g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? Yes No
 - h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? Yes No
 - i. Any disease or disorder of the eyes, ears, nose or throat? Yes No
 - j. Any other illness or injury requiring medical attention or blood transfusions? Yes No

2. During the past 5 years, has any Proposed Insured:
 - a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? Yes No
 - b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? Yes No
 - c. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? Yes No
 - d. Been advised to have any test (*except HIV tests*), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received? Yes No
 - e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related blood tests*) or urine tests? Yes No

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

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

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

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

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

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



PHYSICIAN INFORMATION

Please list the last physician seen:

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

Address _____
Street Address Suite

City State ZIP+4

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

Is this your primary physician? Yes No

Reason for consultation _____

Results _____

AGREEMENT

I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief. I (We) agree that this application shall form a part of the policy if attached thereto.

I (We) agree that:

- a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.
- b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

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

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

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

Signature of Proposed Insured

Signature of Licensed Agent

Print Agent Name and Agent No.



FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

- 1. a. What amount was collected with this application? \$
b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner?
c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice?
2. a. Did you personally see all Proposed Insured(s) on the date of application?
b. How well do you know the Proposed Insured(s)?
c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured?
3. Is this application being submitted on a non-medical basis?
4. a. Is other insurance coverage in force for any Proposed Insured?
b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage?
5. Are commissions to be split?

AUTOMATIC PAYMENT OPTIONS

- Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.
Add to existing bank withdrawal—indicate other applicant and/or policy numbers
Set up NEW credit card payment—submit signed authorization with the application.

LIST BILL

- Set up NEW list bill— submit signed authorization with the application.
Add to existing list bill, indicate list bill no. and/or name of company

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

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





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

**Confidential Information
 AUTHORIZATION**

Name of Applicant/Insured/Claimant (Please print)

____/____/____
 Date of Birth (MM/DD/YYYY)

Name of Additional Applicant/Insured/Claimant (Please print)

____/____/____
 Date of Birth (MM/DD/YYYY)

Applicant/Insured/Claimant Child(ren)			
Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

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

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases (*Except information about human immunodeficiency virus (HIV) infection for Individuals residing in Maine or Vermont.*). For residents of Maine: this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. For residents of Vermont: this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

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

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four (24) months from the date of signature below (*Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below*), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

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

 Date (MM/DD/YYYY)

 Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18

 Signature of Additional Applicant/Insured/Claimant or Legal Representative

 Signature of Applicant/Insured/Claimant Child (if age 18 or older)

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





MIB Pre-Notice

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

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

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

Insurance Information Practices

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

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

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

Fair Credit Reporting Act

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

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

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

Telephone Interview Information

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



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, including the present value of future benefits of any reversionary annuity policy, 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, including the present value of future benefits of any reversionary annuity policy, 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 Cash On Delivery (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") as 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, including the present value of future benefits for any reversionary annuity policy, for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company, including the present value of future benefits for any reversionary annuity policy, 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, P.O. Box 82533, Lincoln, NE 68501
 402.476.6500 • 800.276.7619 • FAX 402.437.4591

**NOTICE AND
 CONSENT**

**NOTICE AND CONSENT FOR TESTING OF
 BIOLOGICAL SPECIMENS TO INCLUDE HIV (AIDS VIRUS) TESTING**

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

EXAMINER: _____

Name

Address

To determine your insurability, the Insurer named above (*the Insurer*) has requested that you provide a biological specimen for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV (*the AIDS virus*), its component parts or its antibodies. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (*fats*), cotinine, cocaine and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If a biological specimen other than blood is tested to determine the presence of HIV virus, its component parts or its antibodies, the Insurer may at a later time request a specimen of your blood for further HIV testing. If you choose to decline that request, the results of all testing which has been performed will be provided to the physician which you have designated to receive such results. In addition, if the insurer is a member of the Medical Information Bureau (*MIB, Inc.*) and you choose to decline the request that you submit a blood specimen for further HIV testing, the Insurer will report to the MIB, Inc. a generic code which specifies only a nonspecific blood test has been ordered and not received. Regardless of the number of tests requested, if the final HIV testing results (*including the results of any confirmatory tests dictated by standard medical practice*) are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a nonspecific test abnormality. If your final HIV testing results are normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you to confirm the name of a physician to whom you authorize disclosure and with whom you may wish to discuss the results. If you are a resident of Missouri and your HIV test(s) indicates confirmed infection with HIV and you have not provided the Insurer with the name of the physician to whom you authorize disclosure of test results, the Insurer will disclose the results to the Missouri Department of Health as required by law.

Positive HIV test results or other significant abnormalities detected by additional tests of biological specimens will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Physician's Name _____

Physician's Address _____

I have read and I understand this Notice of Consent for Testing of Biological Specimens to Include HIV (*AIDS Virus*) Testing. I voluntarily consent to provide body fluids and/or biological specimen(s) for testing, to the testing of such specimens and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

 Proposed Insured (Printed)

 Date of Birth (MM/DD/YYYY)

 Signature of Proposed Insured or Parent/Guardian

 Date (MM/DD/YYYY)

 State of Residence



