

Disability Income Application Instructions

Just print/fill out the application by hand as best you can. On any dates for health history, you only need a month/year and do not need the exact date.

Please fax it to us Toll Free at (877) 718-8056 using this cover page or if you prefer, you may scan/email it back to your agent using his/her email address. Your agent will call you shortly after the application arrives.

Please **DO NOT** mail the application to the address on the forms.

Enter Your Agent's Name: _____

You only need to fax or scan/email the application back to us. We do not need the original.

If you have any questions or need help in any way, please call us Toll Free at (866) 270-6209 and ask for your agent.



PLEASE PRINT IN BLUE OR BLACK INK

To Assurity Life Insurance Company Application State _____
 Agent _____ Agent ID No. _____ Agent Phone No. () _____

PROPOSED INSURED

Legal Name <i>First Middle Last</i>			Date of Birth <i>(MM/DD/YYYY)</i> / /	
Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female	E-mail	Age	
Home Address <i>Street Address City State ZIP+4</i>			Birth State/ Country	
Residence Phone No. ()		Cell Phone No. ()	Business Phone No. ()	
Driver's License No./State			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 <i>(MM/DD/YYYY)</i> / /				
Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident (<i>green card</i>) status? <input type="checkbox"/> Yes <input type="checkbox"/> No If the Proposed Insured has permanent resident status, please list permanent resident (<i>green card</i>) 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 <i>Years Months</i> /				
Primary Employer		Employer's Address <i>Street Address City State ZIP+4</i>		
Full-time Employment <i>Occupation Duties</i>		Part-time Employment <i>Occupation Duties</i>		
Gross monthly Income \$		If self-employed, net monthly income \$		

POLICYOWNER (Policyowner is the Proposed Insured unless otherwise indicated)

Legal Name <i>First Middle Last</i>			Date of Birth <i>(MM/DD/YYYY)</i> / /	
Social Security No.	Relationship to Insured		Birth State/Country	
Home Address <i>Street Address City State ZIP+4</i>			E-mail	
Contingent Owner's Name <i>First Middle Last</i>			Contingent Owner's Relationship to Insured	

BENEFICIARIES

Primary Beneficiary Name <i>(First, Middle, Last)</i>	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
Contingent Beneficiary Name <i>(First, Middle, Last)</i>	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	

PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below:

Type		Frequency		
<input type="checkbox"/> Direct Billing	<input type="checkbox"/> Automatic Bank Withdrawal	<input type="checkbox"/> Annual	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Quarterly
<input type="checkbox"/> List Billing <i>(employer)</i>		<input type="checkbox"/> Monthly <i>(not available with Direct Billing)</i>		

GENERAL SECTION

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

2. a. Is other insurance coverage in force for any Proposed Insured? Yes No
 b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? Yes No
 If either a or b is answered YES, complete and return the appropriate State Replacement Forms *(if applicable)*.



CRITICAL ILLNESS PRODUCT SECTION

Benefit Amount \$ _____

ADDITIONAL BENEFITS (If available)

Check benefit(s) desired and indicate amount requested.

Accidental Death Benefit Rider \$ _____

Disability Waiver of Premium Rider

Spouse Critical Illness Benefit Rider \$ _____
(complete information below)

Dependent Child Critical Illness Benefit Rider \$5,000 \$10,000
(complete information below)

SPOUSE AND CHILD RIDER INFORMATION—If additional space is needed, attach a separate sheet of paper.

Information	Spouse	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name (First, Middle, Last)				
Date of Birth (MM/DD/YYYY)	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Height/Weight	ft. in. / lbs	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employer				
Occupation/Duties				
Gross monthly income \$				
If self-employed, net monthly income \$				

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

If YES, please list type: _____ amount per day: _____ last date of use (MM/DD/YYYY) / /

Is the Proposed Insured's Spouse a United States citizen, or does he/she have permanent resident (*green card*) status? Yes No

If the Proposed Insured's Spouse has permanent resident status, please list permanent resident (*green card*) number.



FIELD UNDERWRITER'S STATEMENT

1. a. What amount was collected with this application? \$ _____
 b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? Yes No
 c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? Yes No
2. a. Did you personally see all Proposed Insured(s) on the date of application? Yes No
 b. How well do you know the Proposed Insured(s)? Well Slightly Not at all
 c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? If YES, please provide details below. Yes No

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. Yes No
Agent is responsible for scheduling exam items.
NOTE: ANY PREFERRED PLANS REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.
 Paramedical examination Blood Sample Urine Sample Electrocardiogram (EKG) Treadmill EKG Medical exam by physician
4. Is other insurance coverage in force for any Proposed Insured? Yes No
5. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? Yes No
6. Was sales material used in soliciting this application? Yes No
7. Was the sales material left with the applicant? Yes No
8. Was the sales material approved by Assurity Life Insurance Company? Yes No
9. Are commissions to be split? Yes No Agent No. _____ % Agent No. _____ %

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 _____

FOR TERM LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:
 \$350,000 and under: Select + NT Select NT Standard NT Select + T Select T Standard T
 \$350,001 and over: Preferred + NT Preferred NT Standard NT Preferred T Standard T
 Other Insured's underwriting classification _____

FOR WHOLE LIFE APPLICATION (either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)

The premiums for this application were quoted on the following underwriting classification:
 \$99,999 and under: Select NT Standard T
 \$100,000 and over: Preferred + NT Preferred NT Select NT Preferred T Standard T
 Other Insured's underwriting classification _____

FOR UNIVERSAL LIFE APPLICATION (either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)

The premiums for this application were quoted on the following underwriting classification:
 Preferred + NT Preferred NT Select NT Preferred T Standard T
 Additional Insured's underwriting classification _____

FOR REVERSIONARY ANNUITY APPLICATION (either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)

The premiums for this application were quoted on the following underwriting classification: Preferred NT Standard NT Tobacco

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

_____/_____/_____(_____)_____/_____(_____)_____
 Signature of Soliciting Agent Date (MM/DD/YYYY) Business Phone No. and Fax No.

 Soliciting Agent's Printed Name Agent No. Agent's E-mail





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)





 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)





NOTICE AND CONSENT FOR HIV-RELATED TESTING

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

To evaluate your insurability, the Insurer named above (*the Insurer*) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (*HIV*) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS:

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

MEANING OF POSITIVE TEST RESULT:

The test is not a test for AIDS. It is a test for the antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS:

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law, or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULTS:

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain the meaning.

Name of physician for reporting a possible positive test result

Address

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

CONSENT:

I have read and I understand this Notice of Consent for HIV-related testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

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

Name of Proposed Insured (Printed)

Signature of Proposed Insured or Parent/Guardian

Address

Date Signed (MM/DD/YYYY)





NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application (*information you have furnished*), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Assurity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain facts which may affect the insurance protection available to you under the new policy.

1. Health conditions that you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date (MM/DD/YYYY)

Applicant's Signature and Printed Name

**Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.**



