

#### **ASSURITY® LIFE INSURANCE COMPANY**

Toll-free Number: (800) 276-7619, Extension 4264 AssureLINK Address: http://assurelink.assurity.com

Term Life

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:

- ✓ Use the appropriate application for the state in which the application is to be signed.
- ▼ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity in the state in which the application is signed.
- ✓ Use age last birthday when preparing illustrations and/or calculating insurance premiums.
- ✓ 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. Note: NAIC Model Illustration or disclosure statement must accompany this application.
- ✓ Complete <u>all other</u> 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 underwriting-related questions (including "what if" scenarios), call toll-free (800) 276-7619, EXT. 4264 or email to underwriting@assurity.com.

### Stranger-Owned Life Insurance/Investor-Owned Life Insurance (STOLI/IOLI)

#### Assurity Life Insurance Company position on STOLI/IOLI

Assurity Life Insurance Company does not support the use of its life insurance products in situations involving Stranger-or Investor-Owned Life Insurance. The company will take all measures necessary to identify these situations and take appropriate action to disallow these transactions. The company views STOLI/IOLI transactions as an inappropriate use of insurance in violation of its intended purpose. In addition, such use of insurance products may be illegal or in connection with illegal activity based on state laws and regulations.

#### **Definition**

Any act, practice or arrangement to initiate or facilitate the issuance of a life insurance policy for the intended benefit of a person who, at the time of the policy origination, does not have an insurable interest in the life of the insured as defined by the company's insurable interest guideline.

#### **Actions**

Safeguards and procedures are in place to identify STOLI/IOLI transactions during the underwriting and issue process. Any activities identified as being in violation of our company position will lead to action including, but not limited to, cancellation of the application or policy and termination of the producer/agent contract(s) and appointment with Assurity Life Insurance Company.

Term Life California



#### **Application for** INDIVIDUAL LIFE INSURANCE PLEASE PRINT IN BLUE OR BLACK INK

1. PROPOSED INSURED									
First	Middle		Last				(MM/E	D/YYYY)	
Legal Name					Date	of Birth	1	/	
Social Security No.	│	e 🗌 Female	Email					Age	
Home Street Address		City			State		ZIP+4	1	
Address									
Personal Phone No. (	Birth St	ate/Country			Height	ft.	in. We	eight	lbs.
Has the Proposed Insured ever used any form of tobac	co or nico	tine-based produc	ts, or substi	tutes such a	s patches	or gum?		☐ Yes	☐ No
If YES, please list type	Amount	per day		Last date	of use (MM	I/DD/YYYY)		1	
Has the Proposed Insured ever used any form of marij	uana? 🔲	Yes ☐ No If Y	ES, please l	ist last date	of use (MM/	(DD/YYYY)		1	
Is the Proposed Insured a United States citizen, or does	the Propos	sed Insured have p	ermanent re	esident (gree	en card) sta	atus?		☐ Yes	□No
If the Proposed Insured has permanent resident status, pl	ease list pe	ermanent resident (	green card)	number					
If not a United States citizen, how long has the Proposed	Insured be	en in the United Sta	ates?						
Does the Proposed Insured have a valid driver's license	? 🗌 Yes	☐ No If YES, p	lease list sta	te of issue ar	nd number:				
								Years	Months
Is the Proposed Insured currently working at least 30 ho	urs per we					th of empl			
Primary Employer	Emplo Addre		SS		City	St	ate	ZIP+4	
Full-time Occupation Duties Employment		Part-tin Employ	IC	pation	Duties	3			
Gross monthly income \$		If self-e	mnloved ne	t monthly inc	come \$				
2. POLICYOWNER (Policyowner is the Proposed Ins	ured unles			t monthly me	DOTTIC U				
If Ownership is a trust, complete the Trust Information			•	e 2) rather t	han this se	ection.			
First	Middle	,	Last				(MM/E	D/YYYY)	
Legal Name					Date of	of Birth	1	1	
Social Security No.	Relation	ship to Insured			Birth State	e/Country			
Coolai Geodifity 140.					Dirtii Otate	5/ Oddina y			
Home Street Address City	1	State	ZIP-	+4					
Home Street Address City Address	1		ZIP-	+4	Email				
Address			ZIP-	T					
Address  Contingent Owner's Name  First Middle		State	ZIP	Contingen Relationsh	t Owner's	ed			
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES		State Last		Contingen Relationsh	t Owner's ip to Insure				
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need.		State  Last  lete the Trust Info	ormation/Ac	Contingen Relationsh	t Owner's ip to Insure neficiary s	ection <i>(p</i>			
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES		State Last	ormation/Ac	Contingen Relationsh	t Owner's ip to Insure neficiary s	ection <i>(p</i>	age 2).	Sh	are %
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need.		State  Last  lete the Trust Info	ormation/Ac	Contingen Relationsh	t Owner's ip to Insure neficiary s	ection <i>(p</i>		Sh	are %
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need.		State  Last  lete the Trust Info	ormation/Ac	Contingen Relationsh	t Owner's ip to Insure neficiary s	ection <i>(p</i>		Sh	are %
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need  Primary Beneficiary Name (First, Middle, Last)	led, comp	State  Last  lete the Trust Info  Relationshi	prmation/Ac	Contingen: Relationsh Iditional Be Soc. Sec. N	t Owner's ip to Insure neficiary s o.	Date o	of Birth /		
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need.	led, comp	State  Last  lete the Trust Info	prmation/Ac	Contingen Relationsh	t Owner's ip to Insure neficiary s o.	Date o			are %
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need  Primary Beneficiary Name (First, Middle, Last)	led, comp	State  Last  lete the Trust Info  Relationshi	prmation/Ac	Contingen: Relationsh Iditional Be Soc. Sec. N	t Owner's ip to Insure neficiary s o.	Date o	of Birth /		
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need Primary Beneficiary Name (First, Middle, Last)  Contingent Beneficiary Name (First, Middle, Last)	led, comp	Last  Last  Relationshi  Relationshi	prmation/Ac	Contingen Relationsh Iditional Be Soc. Sec. N	t Owner's ip to Insure neficiary s o.	Date o	of Birth /		
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need Primary Beneficiary Name (First, Middle, Last)  Contingent Beneficiary Name (First, Middle, Last)  4. PREMIUM PAYMENT—Please indicate preference is	led, comp	Last  Last  Relationshi  Relationshi	prmation/Ac	Contingen Relationsh Iditional Be Soc. Sec. N	t Owner's ip to Insure neficiary s o.	Date o	of Birth /		
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES If Beneficiary is a trust, or if additional space is need Primary Beneficiary Name (First, Middle, Last)  Contingent Beneficiary Name (First, Middle, Last)  4. PREMIUM PAYMENT—Please indicate preference to the second space is need to the second space is need to the second space in the second space is need to the second space in the second space is need to the second space in the second space is need to the second space in the second space is need to the second space in the second space is need to the second space is need	led, comp	Last  Last  Lete the Trust Info  Relationshi  Relationshi  at type and billing	prmation/Ac	Contingen Relationsh Iditional Be Soc. Sec. N	t Owner's ip to Insure neficiary s o.	Date o	of Birth /		
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need Primary Beneficiary Name (First, Middle, Last)  Contingent Beneficiary Name (First, Middle, Last)  4. PREMIUM PAYMENT—Please indicate preference to the sum of the	led, comp	Last  Last  Lete the Trust Info  Relationshi  Relationshi  nt type and billing	p frequency	Contingen Relationsh Iditional Be Soc. Sec. N	t Owner's ip to Insure neficiary s	Date of pate o	of Birth  /  / of Birth  /		
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need Primary Beneficiary Name (First, Middle, Last)  Contingent Beneficiary Name (First, Middle, Last)  4. PREMIUM PAYMENT—Please indicate preference to the second process of the second proc	led, comp	Relationshi  Relationshi  Type and billing  Freque	frequency	Contingen: Relationsh  Iditional Be Soc. Sec. N  Soc. Sec. N	t Owner's ip to Insure neficiary s	Date of / Date o	of Birth  /  / of Birth  /		
Address  Contingent	ded, comp	Relationshi  Tast    Last   Control   Relationshi   Control   Relationshi   Control   Relationshi   Control   Contro	frequency and another the state of the state	Contingen Relationsh Iditional Be Soc. Sec. N	t Owner's ip to Insure neficiary so.	Date of / Date o	f Birth  / / of Birth  / / / ly	Sh	are %
Address  Contingent First Middle Owner's Name  3. BENEFICIARIES  If Beneficiary is a trust, or if additional space is need Primary Beneficiary Name (First, Middle, Last)  Contingent Beneficiary Name (First, Middle, Last)  4. PREMIUM PAYMENT—Please indicate preference to the second process of the second proc	ded, comp	Relationshi  Relationshi  Type and billing  Freque	frequency and another the state of the state	Contingen: Relationsh  Iditional Be Soc. Sec. N  Soc. Sec. N	t Owner's ip to Insure neficiary s	Date of / Date o	of Birth  /  / of Birth  /	Sh	

5. SECONDARY ADDRESSEE							
Legal First Name	Middle	Las	st		Relationship o Insured		
Street Address		City		, u	State	ZIP+4	
Home Address							
	INFORMATIO						
Please complete the following sections if Ownership	and/or Beneficiar	y is a trust <i>(or if a</i>	dditional	room is need	led to list beneficiarie	s of Policy):	
1. POLICYOWNER						(MM/DD/Y	YYY)
Name of Trust					Date of Trust	1	1
Name of Trustee(s)				Tax ID No.			
Street Address		Ci	ty	<u> </u>	State	ZII	P+4
Address of Trustee(s)  2. BENEFICIARIES							
Testamentary Trust (Will)	Share %						
				-			
Living Trust (Please complete information below	v.) Share %			-			
Name of Living Trust					Date of Trust	(MM/DD/Y /	YYY) /
Name of Trustee(s)				Tax ID No.			
Street Address		Ci	ty	TAX ID NO.	State	Zli	P+4
Address of Trustee(s)							
3. ADDITIONAL BENEFICIARIES							
Primary Beneficiary Name (First, Middle, La	ast)	Relationship	Socia	al Security No.	Date of Birth (MI)	<u>1/DD/YYYY)</u>	Share %
					1	/	
					/	/	
					1	1	
					1		
					,	<u>'</u>	
					1	<u></u>	
					/	<u>/</u>	
					1	1	
					/	/	
Contingent Beneficiary Name (First, Middle,	Last)	Relationship	Socia	al Security No.	Date of Birth (MI	1/DD/YYYY)	Share %
					1	1	
					/	/	
					1		
					,	<u>'</u>	
					/	<u>/</u>	
					1	<u> </u>	
					/	1	
					1	1	

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Please answer the follo	wing questions. If addit		attach a senarate she				
	Insured belong to or have	·	·	<u> </u>	nilitary or N		s 🗆 No
	ears or within the next 1	-					
a. Has any Propose	d Insured flown other th	an as a fare-paying pa	assenger, or is any Pro	posed Insured intendi	ng to fly as	s a pilot,	
-	student?						
· ·	d Insured participated in		•				
If YES, check all tha  ☐ Motor-powered F	t apply: ☐ Skin/Scul lacing ☐ Boxing	oa Diving	<ul><li>☐ Bungee Jumping</li><li>☐ Rodeo</li></ul>	· · · · ·		ng/BASE Jumping/Han rofessional or Club Sp	•
☐ Cave Exploration		/Rock/Ice Climbing	☐ Hot Air Balloonin		ai, ocini-pi	rolessional of Oldb op	Orto
· · · · · · · · · · · · · · · · · · ·	nonths, does any Prop			<u> </u>	?	\ \ Ye	s 🗌 No
If YES, please expla	iin						
4. During the past 12 r	nonths, has any Propo	sed Insured had a cha	inge in weight of more	than 10 pounds?		🗆 Ye	s 🗌 No
If YES, please list Pr	oposed Insured's name,	amount of weight cha	nge and details: diet/be	etter eating, exercise, cl	hildbirth, oi	r other:	
	ears, has any Proposed						
organization for suc	h benefits?					Yes	□ No
If YES, please expla	iin						
6. Is any Proposed Ins	ured currently negotiati	ng for other insurance	coverage?			🗌 Ye	s 🗌 No
If YES, please expla	iin						
7. During the past <b>5</b> ye	ears, has any Proposed						
	license suspended or re e (DUI/DWI), or pled gu						s 🗌 No
		-					:5 🔲 110
	in						
	f a felony?						s 🗌 No
If YES, please expla							
	ured currently on proba oposed Insured's name,					\ \ Ye	es 🗌 No
ii 120, piease iist Fi	oposed insured's name,	reason for probation a	and length of probations	яту репос.			
		1 1 0					
•	nsured ever filed for bar	•					s 🗌 No
			been discharged? 🔲		ES, when	-	
10. a. Does any Propos  If YES, provide de		nsurance coverage in	force?			🗌 Ye	s 🗌 No
	s issued, will it replace,	•		~		Ye	s 🗌 No
If YES, and applying	for life insurance cover	age, please complete		•	nt form.	A	
	Company Name		Type of	Coverage		Amount of Cover	age
44 1641		P 4 0 - 4 4 5	, eve			1 10 100	
11. If the Proposed Ins needed, attach a sep	<b>ured is a juvenile</b> , plea parate sheet of paper.	se list the total amoun	t ot lite insurance in for	ce and pending on <b>all</b>	tamily mer	mbers. It additional sp	ace is
Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibl	ling 4 Sib	ling 5
<u></u> -	\$	¢	\$	<u></u>	\$	\$	

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#### **HEALTH SECTION**

Please answer the following questions to the best of your knowledge. If YES to any of the following, please provide details on page 5. **NOTICE:** California law prohibits a human immunodeficiency virus (*HIV*) test from being required or used by health insurance companies as a condition of obtaining health insurance.

	·	
1.	During the past <b>5 years</b> , has any Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:	
	a. Heart disorder, including a heart attack ( <i>myocardial infarction</i> ), angina, irregular heartbeat or irregular heart rhythm ( <i>arrhythmia</i> ), chest pain, hypertension ( <i>high blood pressure</i> ), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack ( <i>TIA or mini-stroke</i> ), or rheumatic fever?	□No
	b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders <i>(other than HIV)</i> , elevated cholesterol, liver disease, hemophilia, kidney disease <i>(other than kidney stones)</i> , protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? Yes	□No
	c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of the lymph nodes or any glandular disorder?	☐ No
	d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (including Down 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?	□No
	e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (COPD), shortness of breath, or asthma or other respiratory disorder?	□No
	f. Dizziness, fainting spells or anxiety, depression, chronic fatigue, eating disorders or any other psychological or emotional disorder? Yes	□No
	g. Arthritis in any form, fibromyalgia, paralysis or connective tissue disorder (such as lupus or scleroderma) or any disease or disorder of the back, spine, bones, joints or muscles?	□ No
	h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia?	☐ No
	i. Any disease or disorder of the eyes, ears, nose or throat, (for example: blindness, blurred vision, diplopia, optic neuritis, loss of hearing or tinnituis (ringing of the ears), Barrett's esophagus or deviated nasal septum)?	□No
2.	During the past <b>5 years</b> , has any Proposed Insured:	
	a. Required a transfusion of whole blood or blood products, including platelets, packed red blood cells or plasma?	☐ No
	b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician?	□No
	c. Been treated or diagnosed by a medical professional as needing treatment for drug or alcohol use?	☐ No
	d. Been diagnosed as having, or been treated by a medical professional for acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or any other disorder of the immune system (excluding HIV status)?	□ No
3.	During the past <b>5 years</b> , has any Proposed Insured:	
	a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?	☐ No
	b. Been ordered by a medical professional to have any test (other than HIV tests), treatment, surgery or hospitalization, or been referred to a specialist for any appointment, test, treatment, surgery or hospitalization which has not been completed or for which results have not been received?	□ No
	c. Had any laboratory tests such as X-rays, electrocardiograms, blood tests (other than AIDS-related blood tests) or urine tests?	□ No
4.	Has any Proposed Insured had a natural parent or sibling who was diagnosed by a medical professional with or died of cancer, heart disease, diabetes, Huntington's disease or polycystic kidney disease prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death.	□No
5.	a. During the past 10 years, has any Proposed Insured been treated for any disorder of any genital or reproductive organ or been treated for a miscarriage, stillbirth or Caesarean section?	□ No
	b. Is any Proposed Insured currently pregnant?	☐ No
	If YES, date child is expected (MM/DD/YYYY) /	
	Is any Proposed Insured currently taking any prescription medication?	☐ No
DE	ETAILS: Enter complete details from question numbers 1-6 on page 5. If more space is needed, attach additional Supplemental Information	form.

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				INFORMATION	
Question	Name	Onset Date	Duration	Health Condition	Medical Care Provider's
#/Letter	(First, Middle, Last)	(MM/DD/YYYY)	(Days, Mos, Yrs)	and Details	Name/Address/Phone
		1 1			
		1 1			
		1 1			
		1 1			
		1 1			
		, ,			
		1 1	1		
		1 /			
	<u> </u>	, ,			
		1 1			
		/ /			
		1 1			
		1 1			
		1 1			
Addition	al Information:				
Home Of	fice Use Only				
7101110 01					

			LIFE PRODI	JCT	SECTION				
1.	What is the purpose of this insurance? [	☐ Personal	☐ Key Person ☐ Bu	uy/Se	Ⅱ ☐ Business Loar	n 🔲 Charitable G	Siving	Other	
2.	a. Are there any agreements in place to	o assign/sell t	he policy?						☐ Yes ☐ No
	b. Is there any intent to sell the policy a	ıfter issuance	?						☐ Yes ☐ No
	c. Has the insured undergone any life ex	xpectancy or l	nealth exams in conjunc	tion v	vith a life insurance ap	oplication or settlem	nent op	tion contract?	☐ Yes ☐ No
3.	Answer only if applying for the Critic from an insurance policy, HMO plan of If NO, indicate below all Proposed Insurance policy.	r other health	n benefit plan?						☐ Yes ☐ No
III:	RM LIFE INSURANCE								
Ea	ice Amount \$		Number of years for po	liov:	☐ 10-Year	☐ 15-Year		.0-Year	☐ 30-Year
	ice Amount \$  DDITIONAL BENEFITS AVAILABLE			•	_	<del>_</del>			_
	Disability Waiver of Premium Rider	ON TERM E	ii L—Oneck benefit(s		Other Insured Leve (complete next page	I Term Rider	su wii	\$	·
	Monthly Disability Income Rider for Primary Insured	\$	mo. benefit		Monthly Disability Ir Other Insured (com			\$	mo. benefit
	Critical Illness Benefit Rider for Primary Insured	\$			Other Insured (com			\$	_
	Children's Term Rider (complete next page)		units		Return of Premium	Rider			
W	HOLE LIFE INSURANCE								
Fa	ice Amount \$								
If c	cash value is available, should the Auto	omatic Premi	um Loan <i>(APL</i> ) provisi	on he	made effective? (If	no ontion chosen	ΔΡΙ ι	will annly )	□ Yes □ No
	onforfeiture Option: (If no option chose		, , ,		nsurance (ETI)	•			
	vidend Option: (If no option chosen, P		,		• •	nulate at Interest		Reduce Prem	ium/PUA
			☐ Reduce Premiu	ım/Ca	ash ☐ Paid ir	n Cash			
ΑC	DDITIONAL BENEFITS AVAILABLE (	ON WHOLE L	IFE—Check benefit(s	) des	ired and indicate a	mount requested	d whe	re applicable	
	Disability Waiver of Premium Benefit I	Rider			Protected Insurabili	ty Benefit Rider		\$	_
	Monthly Disability Income Rider for Primary Insured	\$	mo. benefit		Monthly Disability Ir Other Insured (com			\$	mo. benefit
	Critical Illness Benefit Rider for Primary Insured	\$			Other Insured (com			\$	_
	Children's Term Insurance Rider (complete next page)		units		Accidental Death Benefit Rider			\$	_
	Level Term Insurance Benefit Rider for	or Primary In	sured (Select only one)	):	☐ 10-Year	20-Year		\$	
	Level Term Insurance Benefit Rider -	Other Insu	red (Select only one):		☐ 10-Year	20-Year		\$	_
	Payor Benefit Rider (Complete Health	Section for Pa	ayor) Payor Name			DOB	1		$\square$ M $\square$ F
	Paid-Up Additions Purchase Option (V	(ER)	☐ Periodic Premiums	\$ <u></u>		☐ Single Premiur	n <u>\$</u>		_
SII	NGLE PREMIUM WHOLE LIFE INSU	JRANCE							
Fa	ce Amount \$		☐ Sin	gle F	remium Insurance R	ider <u></u> \$			
Div	vidend Option: (If no option chosen, P	UA will apply	☐ Paid-Up Addition	ons (	<i>PUA)</i> □ Pai	id in Cash			

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### LIFE PRODUCT SECTION (continued)

OTHER INSURED AND	CHILD RIDER INFORMATION-	—If additional space is needed,	attach a separate sheet of pape	r.
Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name (First, Middle, Last)				
Date of Birth (MM/DD/YYYY)	1 1	1 1	1 1	1 1
Age				
Social Security No.				
Birth State/Country				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to Proposed Insured				
Employer and Occupation/Duties		leukemia, disorder of the l	eated for internal cancer or tumor, ymph nodes or glandular disorder'	? Yes No
Personal Phone No.		2. During the past <b>5 years</b> , has	eated for heart disease or disorder any proposed insured child beer	n advised by a
Gross monthly income	\$	not completed, or for which t	ession to have any diagnostic test he results are currently unknown	or pending
If self-employed, net monthly income	\$	If YES to any of the above, plea	ase list child(ren)'s name(s):	
Has the Other Insured 6 (Not applicable to Child F	ever used any form of tobacco or Riders.)	nicotine-based products, or sub-	stitutes such as patches or gum	? Yes No
If YES, please list type		Amount per day	Last date of use (MM/DI	D/YYYY) <u> </u>
Has the Other Insured 6	ever used any form of marijuana?	Yes No If YES,	please list last date of use (MM/DD	wyyyy) <u> </u>
Is the Other Insured a U	Inited States citizen, or does the C	Other Insured have permanent res	sident (green card) status?	Yes No
If the Other Insured has p	permanent resident status, please l	ist permanent resident (green care	d) number.	
If the Other Insured is no	t a United States citizen, how long	has the Other Insured been in the	United States?	
Does the Other Insured	have a valid driver's license?	Yes ☐ No If YES, please list s	state of issue and number.	
Please list the last physic	cian consulted by the Other Insured	I: Is this your primary phys	sician? 🗌 Yes 🔲 No	
Name			Date last consulted	d / / / / / / / / / / / / / / / / / / /
Address Street Addre	ess Suite	City	State	ZIP+4
Phone No. (	)	Fax No	o. <u>(</u>	
Reason for consultation				
Results				

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PHYSICIAN IN	FORMATION		
Please list the last physician consulted:			
Name		Date last consulted	1 1
			MM/DD/YYYY
Address			
Street Address			Suite
City	State		ZIP+4
·			217+4
Phone No. ( )	Fax No. <u>(</u>	)	
Is this your primary physician? ☐ Yes ☐ No			
Reason for consultation			
Results			
AGREE	MENT		
I (We) have read the above questions and answers and declare that they are		the heat of my (our) know	uladge and haliaf I (M/a)
agree that this application shall form a part of the policy if attached thereto.	s complete and true to	the best of my (our) know	wiedge and belief. I (We)
I (We) agree that:			
<ul> <li>a. In the event the first full premium on the policy applied for is paid upon the provided in the Temporary Conditional Insurance Agreement delivered by the</li> </ul>			
b. In the event the first full premium on the policy applied for is not paid upon the			
effect unless: a) The application is approved by the Company at its home	office, b) Such policy is	s issued and delivered to	the Proposed Insured/
Owner, and c) Such first full premium is paid during the Proposed Insured's accurate as of the date the first full premium is paid. When such approval, is			
shall take effect as of the date of issue specified in the policy.			, .
<ul> <li>No agent or medical examiner is authorized or has power to change or was Conditional Insurance Agreement or the policy applied for, or to pass upo</li> </ul>			
d. If the Policyowner is someone other than the Insured, in the event of the become the Policyowner.	Policyowner's death (ar	nd no Contingent Owner(	(s) living), the Insured will
Any person who knowingly, and with intent to defraud any insurance cor of claim containing any materially false information, or conceals for the pathereto, commits a fraudulent insurance act, which is a crime and subject law. The falsity of any statement in the application for insurance shall no statement was made with actual intent to deceive or unless it materially a insurer.	purpose of misleading at to a substantial civil at bar the right to recov	, information concernin penalty where and to the very under the policy ur	g any fact material ne extent allowed by state nless such false
Substitute Form W-9 information (Request for Taxpayer Identification N under penalties of perjury that the number shown is my correct Taxpayer to failure to report interest and dividend income, and I am a U.S. Person not require my consent to any provision of this document other than the	er Identification Numb (including a U.S. resid	er. I am not subject to k ent alien). The Internal l	packup withholding due Revenue Service does
Signed at	on	1	1
City State	<u> </u>	/ Date (MM/DD/YYY)	<u>Y)</u>
Signature of Proposed Insured	S	ignature of Additional Propo	sed Insured
•			
Signature of Parent/Guardian of Minor Child		ignature of Additional Propo	sad Insurad
dignature of t are the Guardian of Willion Office	Si.	gnature of Additional F10po.	Jou mourou
Signature of Owner(s) (If other than Proposed Insured)			
Signature of Licensed Agent		Print Agent Name and Ag	ent No.

49-380-01151 (CA) Page 8 FR.11.16.17

	AGENT STATEMENT							
1.	a. Has a Temporary Conditional Insurance Agreement been given to the Policyowner?	☐ No						
	b. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice?	☐ No						
2.	a. Did you personally see each Proposed Insured on the date of application?	☐ No						
	b. How well do you know the Proposed Insured(s)?							
	c. Did the Proposed Insured approach you to purchase insurance? If YES, list their stated need for the insurance Yes	☐ No						
	d. Did the Proposed Insured(s) directly respond to you regarding each application question?	☐ No						
	e. Was a government-issued picture ID requested and reviewed for the Proposed Insured, Owner and Payor? Yes	☐ No						
	f. Was each Proposed Insured present, and did you witness their signatures at the time the application was taken?	☐ No						
	g. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured(s)? If YES, please provide details below.	□ No						
3.	Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made	□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) ☐ Medical exam by physician							
4.		□ No						
5.		□ No						
6.		☐ No						
7.		☐ No						
8.	Was the sales material approved by Assurity Life Insurance Company?	☐ No						
9.	Are commissions to be split?	%_						
	Agent Name Agent's No	%						
Αl	JTOMATIC 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							
	ST BILL							
	Set up NEW list bill—submit signed employer authorization form with the application.							
	Add to existing list bill; indicate list bill no and/or name of company							
	OR TERM LIFE APPLICATION							
Tr	ne premiums for this application were quoted on the following underwriting classification:  Other Insured's underwriting classification:	n:						
	Preferred Plus NT Preferred NT Standard NT Standard T Standard T							
	OR WHOLE LIFE APPLICATION (either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application) ne premiums for this application were quoted on the following underwriting classification:  Other Insured's underwriting classification	n.						
''	Preferred Plus NT Preferred NT Select NT Preferred T Standard T	l. 						
FC	OR UNIVERSAL LIFE APPLICATION (either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)							
Th	ne premiums for this application were quoted on the following underwriting classification:  Other Insured's underwriting classification	n:						
	Preferred Plus NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T							
l ł	hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and co	rrect.						
	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							

40-381-02251 [R.04.26.17]



#### **Assurity<sup>®</sup> Life Insurance Company**

Post Office Box 82533, Lincoln, NE 68501-2533 402-476-6500 | 800-276-7619 | FAX 877-864-6630

### Confidential Information Authorization

Legal Name of			
Legal Name of Addit	ional Applicant/Insured/Claimant (Please ந	orint)	
Applicant/Insured/Claimant: List chil Legal Name	d(ren) and date(s) of birth  Date of Birth	Legal Name	Date of Birth

I, on behalf of myself or the person named above (Individual), hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. (formerly known as the Medical Information Bureau), financial institution or current or former employer, that has any medical, financial or employment records related to me or my health, to give to Assurity Life Insurance Company (Assurity), or its reinsurers, any such information. This may include:

- 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 sexually transmitted diseases and acquired immune deficiency syndrome (AIDS), excluding the results of tests for human immunodeficiency virus (HIV) unless the Individual has developed symptoms of AIDS.
- 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 sessions (*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.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

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, MIB Inc., consumer reporting agency or employer that has any medical records related to 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 records and information disclosed pursuant to this authorization will not be further disclosed unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four (24) months from the date of 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.

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

49-500-05055 (R11-12) (CA) [FR.10.30.14]



#### **Assurity<sup>®</sup> Life Insurance Company**

Post Office Box 82533, Lincoln, NE 68501-2533 402-476-6500 | 800-276-7619 | FAX 877-864-6630

### Confidential Information Authorization

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

I, on behalf of myself or the person named above (*Individual*), hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. (*formerly known as the Medical Information Bureau*), financial institution or current or former employer, that has any medical, financial or employment records related to me or my health, to give to Assurity Life Insurance Company (*Assurity*), or its reinsurers, any such information. This may include:

- 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 sexually transmitted diseases and acquired immune deficiency syndrome (AIDS), excluding the results of tests for human immunodeficiency virus (HIV) unless the Individual has developed symptoms of AIDS.
- 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 sessions (*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.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

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, MIB Inc., consumer reporting agency or employer that has any medical records related to 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 records and information disclosed pursuant to this authorization will not be further disclosed unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four (24) months from the date of 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.

ORIGINAL TO HOME OFFICE. COPY TO BE LEFT WITH APPLICANT

49-500-05055 (R11-12) (CA) [FR.10.30.14]



Date (MM/DD/YYYY)

Signature of Additional Applicant/Insured/Claimant or Legal Representative

# **Assurity**<sup>®</sup> **Life Insurance Company**Post Office Box 82533, Lincoln, NE 68501-2533 402-476-6500 | 800-276-7619 | FAX 877-864-6630

Confidential Information Authorization for Release of Psychotherapy Notes

· · · · · · · · · · · · · · · · · · ·	·		,
Local Name of Ann	oliaant/laaurad/Claimant/Dlaaca nri	nd)	
Legai Name or App	olicant/Insured/Claimant (Please pri	nı)	Date of Birth (MM/DD/YYYY)
			1 1
Legal Name of Additiona	al Applicant/Insured/Claimant (Pleas	se print)	Date of Birth (MM/DD/YYYY)
Applicant/Incurs d/Claimant, List shild/ra	and data(a) of hirth		
Applicant/Insured/Claimant: List child(re Legal Name	Date of Birth	Legal Name	Date of Birth
I, on behalf of myself or the person named other medical or medically related facility, ir or current or former employer, that has any Company (Assurity), or its reinsurers, any su	nsurance company, MIB Inc. <i>(form</i> medical, financial or employment	nerly known as the Medical Inform records related to me or my health	ation Bureau), financial institution,
<ul> <li>Psychotherapy notes</li> </ul>	•		
I understand that this information may be rele insurance companies with which the Individua may be submitted. By this authorization, I furth	al has policies or to whom applicat	ions may be made, or to whom clai	ms for benefits have been made or
By my signature below, I acknowledge that this authorization, and I instruct any licens custodians, other medical or medically relat has medical records related to the Individu without restriction. The medical information existing policy and/or eligibility for benefits not be further disclosed unless another auth	ed physician, medical practitione ed facility, insurance or reinsurar al or their health, to release and so acquired will be used to dei under a policy. I understand that	er, hospital, clinic, pharmacy or phance company, MIB Inc., consumer I disclose the Individual's entire matermine eligibility for insurance, increcords and information disclosed	armacy benefit manager, records reporting agency or employer that edical record as described above cluding additional coverage to an pursuant to this authorization will
I further agree to execute additional documer application for insurance or claim for benefits,			
This authorization is valid for twelve (12) mo insurance policy, policy reinstatement or cl representative, will receive a copy of this authorization. I further understand that if I been issued, may not be able to make any be	aim. A copy of this authorization uthorization if requested. I unders tand that a revocation is not eff refuse to sign this authorization, A	n is as valid as the original. I und tand that I have the right to revoke fective to the extent that action ha	derstand that I, or my authorized e this authorization at any time by as been taken in reliance on this
This authorization complies with the Hea	Ith Insurance Portability and Ac	ccountability Act (HIPAA) Privacy	Rule.

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

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

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

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

49-502-05055 (R11-12) (CA) [FR.10.09.14]



### **Confidential Information Authorization for Release** of Psychotherapy Notes

Legal Name o	f Applicant/Insured/Claimant (Please print)		Date of Birth (MM/DD/YYYY)
			1 1
Legal Name of Additional Applicant/Insured/Claimant (Please print)			Date of Birth (MM/DD/YYYY)
Applicant/Insured/Claimant: List ch	ild(ren) and date(s) of birth  Date of Birth	Legal Name	Date of Birth
other medical or medically related facil or current or former employer, that has	amed above (Individual), hereby author ity, insurance company, MIB Inc. (forme any medical, financial or employment reny such information. This may include:	rly known as the Medical Inform	<i>ation Bureau),</i> financial institution
understand that this information may b nsurance companies with which the Ind	e released by Assurity and/or its reinsurer ividual has policies or to whom application I further authorize Assurity, or its reinsurers	ns may be made, or to whom clai	ms for benefits have been made
his authorization, and I instruct any licustodians, other medical or medically has medical records related to the Incurrent without restriction. The medical informexisting policy and/or eligibility for ben	that any agreements I have made to recensed physician, medical practitioner, related facility, insurance or reinsurance ividual or their health, to release and dation so acquired will be used to determine the properties of the p	hospital, clinic, pharmacy or phe company, MIB Inc., consumer isclose the Individual's entire memine eligibility for insurance, incords and information disclosed	armacy benefit manager, record reporting agency or employer the edical record as described about cluding additional coverage to a pursuant to this authorization w
further agree to execute additional doc application for insurance or claim for ber	uments that may be necessary to permit nefits, including, but not limited to, federal	Assurity to obtain medical and/or and/or state tax records and Socia	financial information relevant to r al Security Administration records
nsurance policy, policy reinstatement representative, will receive a copy of the providing written notice to Assurity. I ur	P) months from the date of signature belower claim. A copy of this authorization in authorization if requested. I understanderstand that a revocation is not effect if I refuse to sign this authorization, Assembly benefit payments.	s as valid as the original. I und nd that I have the right to revoke tive to the extent that action ha	derstand that I, or my authorize this authorization at any time as been taken in reliance on the
Γhis authorization complies with the	Health Insurance Portability and Acco	ountability Act <i>(HIPAA)</i> Privacy	Rule.
/ / Date (MM/DD/YYYY)	Signature of Applicant/Insured/Cla	aimant, Legal Representative or Pa	arent of Child(ren) under age 18
Signature of Additional Applicant/Insure	d/Claimant or Legal Representative	Signature of Applicant/Insured/C	Slaimant Child (if age 18 or older)
Description of Legal Repres	sentative's Authority for Applicant/Insured/0	Claimant (please indicate which Ind	lividual is represented)
_	DIOINAL TO HOME OFFICE COST	DE LEET WITH A DOLLAR	
U	RIGINAL TO HOME OFFICE, COPY TO	DE LEFT WITH APPLICANT	

49-502-05055 (R11-12) (CA) [FR.10.09.14]

#### **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.

75-652-05055 [R.04.07.09]



# Temporary Conditional Insurance Agreement (for use with Life and Reversionary Annuity products)

Proposed Insured No. 1		Date Application Signed	1	1
Proposed Insured No. 2		Date Application Signed	1	l
temporary life insurance		above (Application), Assurity Life Insurance Company (Assin this Agreement. Make all checks payable to Assurity. Do		
	NOTE: On questions 1-2 answer accordin If questions 3 a-d are answered YES or are left BL. The agent is not authorized to accept a	ANK, there will be NO CONDITIONAL COVERAGE		
1. a. LIFE—Is any Proposed Insured younger than 15 days old or older than 75 years old?				
Assurity exceed	- · · · · · · · · · · · · · · · · · · ·	0,000 for ages 70 through 75?	🗌 Yes	□No
	uity—Does the in-force and applied for life coverage, in the second seco	ncluding the present value of any reversionary	🗌 Yes	☐ No
3. Has any Proposed I	Insured:			
	•	oke; paralysis or cancer?	🗌 Yes	☐ No
	osed or treated by a medical professional for acquired		□ V	N.
	• • •	atmost for druggleehal abuse?		□ No
· ·	<b>5 years</b> been treated, counseled or advised to seek tre <b>50 days</b> been admitted, or advised by a medical profes	atment for drug/alcohol abuse?	🔲 162	☐ No
	ty; had surgery or had surgery recommended by a med			
professional to ha	ave any diagnostic test that was not completed (exclude	ling an AIDS-related test)?	🗌 Yes	☐ No
◆ Until the later of 1) unless honored by  ◆ Unless the Propose according to its ur  If Proposed Insured diese issued at standard rates. Coverage under this Ag. If no Policy is issued ar or if a Policy amendment if the change occurs aft.  Coverage under this Ag.  ◆ 90 days from the de.  ◆ Premium is returne.  ◆ Coverage starts ur  ◆ A Policy resulting for The undersigned state.	No coverage starts:  ◆ Until the later of 1) the date the Proposed Insured completed and signed the Application and paid the first full modal premium (a check is not payment unless honored by the issuing institution when first presented); or 2) the date the Proposed Insured completed all medical tests required by Assurity and  ◆ Unless the Proposed Insured is insurable on the date coverage starts at Assurity's standard or better than average rates (no ratings included), according to its underwriting practices for the amount of insurance and any additional benefits applied for.  If Proposed Insured dies while coverage under this Agreement is in effect, Assurity will pay the death benefit payable if the Policy applied for would have been issued at standard rates. However, Assurity shall not be liable for payment of any benefit over the amount of \$500,000 (\$250,000 for ages 70 through 75). Coverage under this Agreement is subject to the same terms, including any limitations or exclusions, which would be part of the Policy if issued as applied for. If no Policy is issued and delivered and no benefit is paid under this Agreement, all premiums paid will be returned. If the Policy is issued as applied for, or if a Policy amendment is accepted by the Proposed Owner, premium paid will be applied to that Policy. No change in health will be used to deny a Policy if the change occurs after the later of: 1) the date of the Application; or 2) completion of all medical tests required by Assurity.  Coverage under this Agreement terminates automatically on the earliest of the date:  ◆ 90 days from the date of the Application;  ◆ Premium is returned by Assurity (return is effective on being postmarked, properly addressed and postage prepaid);  ◆ Coverage starts under any Policy resulting from the Application; or  ◆ A Policy resulting from the Application is refused by the Proposed Owner.  The undersigned states that the answers on this Agreement and the Application are true and complete to the best of his/her knowledge and beli			
Dated at		On		
	City, State	Date (MM/DD/YYYY)		
Sig	gnature of Proposed Insured No. 1	Signature of Proposed Insured No. 2		
Signature of	of Agent or Witness (disinterested person)	Print Agent or Witness Name		
Signature	of Owner (if other than Proposed Insured)			

75-802-05055 [FR.01.24.11]



### **Temporary Conditional** Insurance Agreement (for use with Life and Reversionary Annuity products)

Proposed Insured No	.1	Date Application Signed	1	1
Proposed Insured No	. 2	Date Application Signed	1	l
temporary life insurar		d above (Application), Assurity Life Insurance Company (Assad in this Agreement. Make all checks payable to Assurity. Do		
	If questions 3 a-d are answered YES or are left B	ng to what product(s) is being applied for.  LANK, there will be NO CONDITIONAL COVERAGE t a premium under these circumstances.		
1. a. LIFE—Is any Proposed Insured younger than 15 days old or older than 75 years old?				
Assurity excee		50,000 for ages 70 through 75?	🗌 Yes	□No
	nnuity—Does the in-force and applied for life coverage, ceed \$100,000?	including the present value of any reversionary	🗌 Yes	☐ No
3. Has any Propose	d Insured:			
	•	stroke; paralysis or cancer?	🗌 Yes	☐ No
	gnosed or treated by a medical professional for acquire		□ V	□ Na
	,	to atmost for drug/alachal abusa?		□ No
• .	it <b>9 days</b> been iteated, counseled of advised to seek it	reatment for drug/alcohol abuse?	🔲 162	☐ No
	cility; had surgery or had surgery recommended by a me			
professional to	have any diagnostic test that was not completed (exclu	uding an AIDS-related test)?	🗌 Yes	☐ No
◆ Until the later of unless honored ◆ Unless the Propaccording to its If Proposed Insured dissued at standard rat Coverage under this If no Policy is issued or if a Policy amendr if the change occurs Coverage under this ◆ 90 days from the ◆ Premium is retur ◆ Coverage starts ◆ A Policy resultin The undersigned star	No coverage starts:  ◆ Until the later of 1) the date the Proposed Insured completed and signed the Application and paid the first full modal premium (a check is not payment unless honored by the issuing institution when first presented); or 2) the date the Proposed Insured completed all medical tests required by Assurity and  ◆ Unless the Proposed Insured is insurable on the date coverage starts at Assurity's standard or better than average rates (no ratings included), according to its underwriting practices for the amount of insurance and any additional benefits applied for.  If Proposed Insured dies while coverage under this Agreement is in effect, Assurity will pay the death benefit payable if the Policy applied for would have been issued at standard rates. However, Assurity shall not be liable for payment of any benefit over the amount of \$500,000 (\$250,000 for ages 70 through 75). Coverage under this Agreement is subject to the same terms, including any limitations or exclusions, which would be part of the Policy if issued as applied for. If no Policy is issued and ho benefit is paid under this Agreement, all premiums paid will be returned. If the Policy is issued as applied for, or if a Policy amendment is accepted by the Proposed Owner, premium paid will be applied to that Policy. No change in health will be used to deny a Policy if the change occurs after the later of: 1) the date of the Application; or 2) completion of all medical tests required by Assurity.  Coverage under this Agreement terminates automatically on the earliest of the date:  ◆ 90 days from the date of the Application;  ◆ Premium is returned by Assurity (return is effective on being postmarked, properly addressed and postage prepaid);  ◆ Coverage starts under any Policy resulting from the Application; or  ◆ A Policy resulting from the Application is refused by the Proposed Owner.  The understands that the answers are relied upon for coverage under this Agreement. Assurity's liability will be limited to a return of the premium submitt			
Dated at		On		
	City, State	Date (MM/DD/YYYY)		
	Signature of Proposed Insured No. 1	Signature of Proposed Insured No. 2		
Signatui	re of Agent or Witness (disinterested person)	Print Agent or Witness Name		
Signatu	re of Owner (if other than Proposed Insured)			

75-802-05055 [FR.01.24.11]

## NOTICE AND CONSENT FOR BLOOD TESTING

### BLOOD TESTING WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING APPLICATION FOR LIFE OR DISABILITY INCOME INSURANCE

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

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the Insurer to withdraw blood and order laboratory tests only in regard to your present application for life or disability income insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the human immunodeficiency virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

#### **TESTS TO BE PERFORMED**

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to the standards of performance and results specified in the manufacturer's Federal Food and Drug Administration approved product circular for the Western Blot Assay reagents and laboratory apparatus.

#### **MEANING OF POSITIVE TEST RESULTS**

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test/screening results or other significant blood abnormalities 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 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 involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the MIB, Inc. (formerly known as Medical Information Bureau), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. 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.

#### **COST OF TESTING**

The cost of any testing will be borne by the Insurer.

#### **NOTIFICATION OF TEST RESULTS**

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 your designated physician, or you if you have not designated a physician. The Insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

#### **TIME LIMIT**

This Consent shall be valid for a period of 30 months from the date noted below.

#### **CONSENT**

I have read and I understand this Notice and Consent for Blood Testing, which will include HIV antibody/antigen testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood 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 a as the original.	is form will be as valid	
Proposed Insured (Printed)		Date of Birth (MM/DD/YYYY)
Name and Address of Designated Physician:		
Signature of Proposed Insured or Parent/Guardian	Date (MM/DD/YYYY)	State of Residence

#### **COUNSELING RESOURCES LIST**

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Assurity Life Insurance Company (Assurity). Therefore, Assurity makes no representations or warranties that this information is accurate as of the date you receive this list. Also, Assurity makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE - U.S. PUBLIC HEALTH SERVICE

(800) 367-AIDS

AIDS HOTLINE - SOUTHERN CALIFORNIA

(800) 367-AIDS

SPANISH AIDS HOTLINE

(800) 344-7432

TTY INFORMATION

Information and Referral for Hearing Impaired

(213) 464-0029

HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA Social Services-Southern California

Hemphilia AIDS Information

(818) 792-6192

(714) 740-2222

KERN COUNTY AIDS TEAM - BAKERSFIELD

(661) 868-0366

CALIFORNIA DEPT. OF HEALTH SERVICES Statewide Services – Office of AIDS – Sacramento

(916) 323-7415

CENTRAL VALLEY AIDS TEAM - FRESNO

(209) 264-2436

AIDS SVCS FOUNDATION OF ORANGE COUNTY - COSTA MESA

(949) 809-5700

AIDS PROJECT-EAST BAY - OAKLAND

(415) 420-8181

AIDS PROJECT - LOS ANGELES - WEST HOLLYWOOD

(213) 876-8951

SACRAMENTO AIDS FOUNDATION-SACRAMENTO

(916) 448-2437

INLAND AIDS PROJECT

Riverside/San Bernardino Counties

(760) 391-8828

SAN FRANCISCO AIDS FOUNATION

San Francisco (415) 846-5855 SAN DIEGO AIDS PROJECT (619) 296-2120 – City of San Diego

(619) 945-6000 - City of Vista

SANTA CLARA COUNTY ARIS PROJECT

Campbell (408) 792-3729

SANTA BARBARA COUNTY AIDS HOTLINE

(805) 681-5120

SONOMA COUNTY AIDS INFORMATION HOTLINE

(707) 579-AIDS

Social Services - Southern California

SHASTA COUNTY HELPLINE

(530) 225-5298

49-820-05055 (R02-15) (CA) Page 3 [FR10.04.16]

Life Insurance or Annuity REPLACEMENT NOTICE

#### REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature and Printed Name		Date (MM/DD/YYYY)	
Agent's Signature and Printed Nan	Date (MM/DD/YYYY)		
INFORMATION ON POLICIES WHICH MAY BE REPLACE	ED		
COMPANY NAME	POLICY NO.	NAME OF INSURED	

To be completed if replacing another company's policy Signed form to be returned to home office Applicant to receive a copy of this form at the time the application is taken



49-808-05055 (CA)

[05.17.07]

Life Insurance or Annuity REPLACEMENT NOTICE

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Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

Applicant's Signature and Printed Name		Date (MM/DD/YYYY)	
Agent's Signature and Printed Name		Date (MM/DD/YYYY)	
NFORMATION ON POLICIES	WHICH MAY BE REI	PLACED	
	1AME	POLICY NO.	NAME OF INSURED
COMPANY N			
COMPANY N			

To be completed if replacing another company's policy Signed form to be returned to home office Applicant to receive a copy of this form at the time the application is taken





I have read the above notice and have received a copy.

Life Insurance or Annuities PURCHASER'S NOTICE

#### California Elder Notice to All Purchasers of Life Insurance or Annuities Age 65 or Over

You should be aware that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this life or annuity product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale or sold.

Signature and Printed Name of Prospective Purchaser	Date (MM/DD/YYYY)
Signature and Printed Name of Prospective Purchaser's Spouse or Joint Owner	Date (MM/DD/YYYY

49-821-05055 (CA) [05.31.07]





I have read the above notice and have received a copy.

Life Insurance or Annuities PURCHASER'S NOTICE

#### California Elder Notice to All Purchasers of Life Insurance or Annuities Age 65 or Over

You should be aware that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity or other asset to fund the purchase of this life or annuity product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your representative may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale or sold.

Signature and Printed Name of Prospective Purchaser

Signature and Printed Name of Prospective Purchaser's Spouse or Joint Owner

Date (MM/DD/YYYY)

Signature and Printed Name of Prospective Purchaser's Representative

Date (MM/DD/YYYY)

49-821-05055 (CA) [05.31.07]

California Resident's MEDI-CAL DISCLOSURE

#### NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

For Distribution by Insurers, Agents and Brokers

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

#### **RECOVERY**

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

#### **UNMARRIED RESIDENT**

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than \$2,000 in countable resources. The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of \$35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

#### MARRIED RESIDENT

- Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than \$119,220 in countable resources.
- Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income, or \$2,981 in monthly income, whichever is greater.

#### FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than \$119,220 in countable resources. The order also may allow the at-home spouse to retain more than \$2,981 in monthly income.

#### REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

#### **REAL PROPERTY EXEMPTIONS**

- One principal residence: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home some day. The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it. Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- Real property used in a business or trade: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

#### PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

- IRAs, Keogh plans, or other work-related pension plans: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity or otherwise change the form of the assets in order for them to be unavailable.
- Personal property used in a trade or business.

I have read the above notice and have received a copy.

- One motor vehicle.
- Irrevocable burial trusts or irrevocable prepaid burial contracts.

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

**Please note:** If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh or work-related retirement arrangements, you may contact your local county welfare department.

Purchaser's Signature and Printed Name	Date (MM/DD/YYYY)
Spouse's Signature and Printed Name	Date (MM/DD/YYYY)
Legal Representative's Signature and Printed Name	Date (MM/DD/YYYY)



### Assurity<sup>®</sup> Life Insurance Company

Post Office Box 82533, Lincoln, NE 68501-2533 402-476-6500 | 800-276-7619 | FAX 877-864-6630

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Purchaser's Signature and Printed Name	Date (MM/DD/YYYY)
Spouse's Signature and Printed Name	Date (MM/DD/YYYY)
Legal Representative's Signature and Printed Name	Date (MM/DD/YYYY)



# Automatic PREMIUM PAYMENT PLEASE PRINT WITH BLACK INK

Name of Proposed Insured			
	First	Middle	Last
drafts to my account listed for premit current. I also understand that if the remain in effect until revoked by me i in requesting any draft to my accoun honored, my policy may lapse and Assurity has approved the application	ums as selected. I understand day selected falls on a week n a manner provided by law. It. I further understand that if require evidence of insurabil n for issue and all policy requi	that initiating automatic payments mend, my account may be charged or Jntil such notice of revocation is rece the day of the draft is after the policy ity for reinstatement. The initial prer	aska (hereafter referred to as Assurity), to initiate ay result in additional drafts to bring my account in the next business day. This authorization shall ived, I agree that Assurity shall be fully protected issue date and the payment for premium is not mium payment will be applied only if and when age will be in force until the premium is paid.
AUTOMATIC BANK WITHDRAWA	L AUTHORIZATION		
			ue date will be used. Assurity will begin processing osted to your account could be two or more days
Please choose an initial premium pa	yment option: (If no option is s	selected, the initial and recurring premiu	m payments will be drafted from your account.)
☐ Draft the initial and recurring pre	mium payments.		
☐ Draft <b>recurring</b> premium payment	s only. Initial premium paymen	t will be paid by: 🔲 Payment enclose	d or ☐ Payment collected on delivery
Type of Account:	☐ Savings		
Name of Financ	ial Institution	Routing No. (9-digit numbe	er) Account No.
Account Holder's Printed N	lame (if other than Proposed Ii	nsured/Owner) Rela	tionship (if other than Proposed Insured/Owner)
Account Holder's Address	(Street Address, P.O. Box, City	/ State. Zip+4)	Name of Authorized Officer (if any)
		, - ····· 2) — ' <b>r</b> - 'y	5
			( )
Signature of Account Ho	older or Authorized Officer	Date (MM/DD/YYY)	Telephone No.

TO ENSURE ACCURACY, SUBMIT VOIDED CHECK

(unless application is submitted electronically)

75-050-05055 (R10-14) [R.10.21.14]

# Automatic PREMIUM PAYMENT PLEASE PRINT WITH BLACK INK

Name of Proposed Insured		
First	Middle	Last
By my signature below, I hereby request and authorize Assurity Life Insuran drafts to my account listed for premiums as selected. I understand that initia current. I also understand that if the day selected falls on a weekend, my remain in effect until revoked by me in a manner provided by law. Until such in requesting any draft to my account. I further understand that if the day o honored, my policy may lapse and require evidence of insurability for rei Assurity has approved the application for issue and all policy requirements have	ating automatic payments may re account may be charged on the notice of revocation is received, f the draft is after the policy issinstatement. The initial premium	esult in additional drafts to bring my account next business day. This authorization shall I agree that Assurity shall be fully protected ue date and the payment for premium is not I payment will be applied only if and when
AUTOMATIC BANK WITHDRAWAL AUTHORIZATION		
Day of Withdrawal Withdrawal day <i>cannot</i> be the 29 <sup>th</sup> , 30 <sup>th</sup> or 31 <sup>st</sup> . If no your bank draft on the day selected. Due to the bank's processing time, the after the day selected.		
Please choose an initial premium payment option: (If no option is selected, the	ne initial and recurring premium pa	nyments will be drafted from your account.)
☐ Draft the <b>initial and recurring</b> premium payments.		
☐ Draft <b>recurring</b> premium payments only. Initial premium payment will be pa	aid by: 🔲 Payment enclosed o	r 🔲 Payment collected on delivery
Type of Account:		
Name of Financial Institution	Routing No. (9-digit number)	Account No.
Account Holder's Printed Name (if other than Proposed Insured/Ov	ner) Relations	hip (if other than Proposed Insured/Owner)
Account Holder's Address (Street Address, P.O. Box, City, State, Z	ip+4)	Name of Authorized Officer (if any)
	1 1	( )
Signature of Account Holder or Authorized Officer	Date (MM/DD/YYYY)	Telephone No.

TO ENSURE ACCURACY, SUBMIT VOIDED CHECK

(unless application is submitted electronically)

75-050-05055 (R10-14) [R.10.21.14]