

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 all other pertinent and applicable forms padded together in this application.
- ✓ If faxing an application directly to the home office, fax to (877) 864-6630.
- ✓ If mailing directly to the home office, address to:  
Assurity Life Insurance Company  
Attn: New Business Unit  
PO Box 82533  
Lincoln NE 68501-2533

To check the **status of an application**, ask **underwriting-related questions** (*including "what if" scenarios*), **call toll-free** (800) 276-7619, EXT. 4264 **or email** to [underwriting@assurity.com](mailto: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.



**1. 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		Email	
Home Address <i>Street Address</i>		<i>City</i>		<i>State ZIP+4</i>	
Personal Phone No. ( )		Birth State/Country		Height ft. in. Weight lbs.	
Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No					
If YES, please list type _____ Amount per day _____ Last date of use (MM/DD/YYYY) / /					
Has the Proposed Insured ever used any form of marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list last date of use (MM/DD/YYYY) / /					
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 _____					
If not a United States citizen, how long has the Proposed Insured been in the United States? _____					
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number: _____					
Is the Proposed Insured currently working at least 30 hours per week in primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of employment _____ / <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 \$		

**2. POLICYOWNER (Policyowner is the Proposed Insured unless otherwise indicated)**

If Ownership is a trust, complete the Trust Information/Additional Beneficiary section (page 2) rather than this section.

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</i>		<i>City</i>		<i>State ZIP+4</i>	
Contingent Owner's Name <i>First Middle Last</i>		Contingent Owner's Relationship to Insured			

**3. BENEFICIARIES**

If Beneficiary is a trust, or if additional space is needed, complete the Trust Information/Additional Beneficiary section (page 2).

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 %
			/ /	
			/ /	

**4. PREMIUM PAYMENT—Please indicate preference for payment type and billing frequency below**

What amount was collected with this application? \$ \_\_\_\_\_

<b>Type</b>		<b>Frequency</b>	
<input type="checkbox"/> Direct Billing <input type="checkbox"/> Automatic Bank Withdrawal <input type="checkbox"/> List Billing ( <i>employer</i> )		<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly ( <i>not available with Direct Billing</i> )	
Payor Name <i>First Middle Last</i>		Billing Address <i>Street Address City State ZIP+4</i>	



## GENERAL SECTION

Please answer the following questions. If additional space is needed, attach a separate sheet of paper.

1. Does any Proposed Insured belong to or have they entered into a written agreement to become a member of the military or National Guard?  Yes  No

2. During the past **5 years** or within the next **12 months**:

a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured intending to fly as a pilot, crew member or student? .....  Yes  No

b. Has any Proposed Insured participated in any of the following sports or activities? .....  Yes  No

- If YES, check all that apply:
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Skin/Scuba Diving                              | <input type="checkbox"/> Bungee Jumping             | <input type="checkbox"/> Skydiving/Parachuting/BASE Jumping/Hang Gliding |
| <input type="checkbox"/> Motor-powered Racing                           | <input type="checkbox"/> Boxing                     | <input type="checkbox"/> Rodeo   |
| <input type="checkbox"/> Cave Exploration                               | <input type="checkbox"/> Mountain/Rock/Ice Climbing | <input type="checkbox"/> Hot Air Ballooning                              |
| <input type="checkbox"/> Professional, Semi-professional or Club Sports |   |  |

3. During the next **12 months**, does any Proposed Insured intend to reside or travel outside of the United States? .....  Yes  No

If YES, please explain \_\_\_\_\_

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? .....  Yes  No

If YES, please list Proposed Insured's name, amount of weight change and details: diet/better eating, exercise, childbirth, or other:

\_\_\_\_\_

5. During the past **5 years**, has any Proposed Insured received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits?.....  Yes  No

If YES, please explain \_\_\_\_\_

6. Is any Proposed Insured currently negotiating for other insurance coverage? .....  Yes  No

If YES, please explain \_\_\_\_\_

7. During the past **5 years**, has any Proposed Insured:

a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence (*DUI/DWI*), or pled guilty or been convicted of any moving violations?.....  Yes  No

If YES, please explain \_\_\_\_\_

b. Been convicted of a felony?.....  Yes  No

If YES, please explain \_\_\_\_\_

8. Is any Proposed Insured currently on probation? .....  Yes  No

If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

\_\_\_\_\_

9. Has any Proposed Insured ever filed for bankruptcy?.....  Yes  No

If YES, when? \_\_\_\_\_ Has the bankruptcy been discharged?  Yes  No If YES, when? \_\_\_\_\_

10. a. Does any Proposed Insured have other insurance coverage in force? .....  Yes  No

If YES, provide details below.

b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage?.....  Yes  No

If YES, and applying for life insurance coverage, please complete and return the appropriate State Replacement form.

Company Name	Type of Coverage	Amount of Coverage

11. **If the Proposed Insured is a juvenile**, please list the total amount of life insurance in force and pending on **all** family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
\$	\$	\$	\$	\$	\$	\$

## 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 **5 years**, 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 (*myocardial infarction*), angina, irregular heartbeat or irregular heart rhythm (*arrhythmia*), chest pain, hypertension (*high blood pressure*), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack (*TIA or mini-stroke*), or rheumatic fever? .....  Yes  No
  - b. Diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders (*other than HIV*), elevated cholesterol, liver disease, hemophilia, kidney disease (*other than kidney stones*), protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, 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? .....  Yes  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? .....  Yes  No
  - e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease (*COPD*), shortness of breath, or asthma or other respiratory disorder? .....  Yes  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? .....  Yes  No
  - h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? .....  Yes  No
  - i. Any disease or disorder of the eyes, ears, nose or throat, (for example: blindness, blurred vision, diplopia, optic neuritis, loss of hearing or tinnitus (ringing of the ears), Barrett's esophagus or deviated nasal septum)? .....  Yes  No
2. During the past **5 years**, has any Proposed Insured:
  - a. Required a transfusion of whole blood or blood products, including platelets, packed red blood cells or plasma? .....  Yes  No
  - b. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? .....  Yes  No
  - c. Been treated or diagnosed by a medical professional as needing treatment for drug or alcohol use? .....  Yes  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*)? .....  Yes  No
3. During the past **5 years**, has any Proposed Insured:
  - a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? .....  Yes  No
  - b. 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? .....  Yes  No
  - c. Had any laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related blood tests*) or urine tests? .....  Yes  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. ....  Yes  No  

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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? .....  Yes  No  
b. Is any Proposed Insured currently pregnant? .....  Yes  No  
If YES, date child is expected (*MM/DD/YYYY*) \_\_\_\_ / \_\_\_\_ / \_\_\_\_
6. Is any Proposed Insured currently taking any prescription medication? .....  Yes  No

**DETAILS:** Enter complete details from question numbers 1-6 on page 5. If more space is needed, attach additional Supplemental Information form.



**LIFE PRODUCT SECTION**

1. What is the purpose of this insurance?  Personal  Key Person  Buy/Sell  Business Loan  Charitable Giving  Other \_\_\_\_\_

2. a. Are there any agreements in place to assign/sell the policy? .....  Yes  No

b. Is there any intent to sell the policy after issuance? .....  Yes  No

c. Has the insured undergone any life expectancy or health exams in conjunction with a life insurance application or settlement option contract?  Yes  No

3. **Answer only if applying for the Critical Illness rider.** Do all Proposed Insureds currently have comprehensive health insurance benefits from an insurance policy, HMO plan or other health benefit plan? .....  Yes  No  
If NO, indicate below all Proposed Insureds who do not have such coverage as they are not eligible for this rider.

**TERM LIFE INSURANCE**

Face Amount \$ \_\_\_\_\_ Number of years for policy:  10-Year  15-Year  20-Year  30-Year

**ADDITIONAL BENEFITS AVAILABLE ON TERM LIFE—Check benefit(s) desired and indicate amount requested where applicable.**

- Disability Waiver of Premium Rider
- Monthly Disability Income Rider for Primary Insured \$ \_\_\_\_\_ mo. benefit
- Critical Illness Benefit Rider for Primary Insured \$ \_\_\_\_\_
- Children's Term Rider (complete next page) \_\_\_\_\_ units
- Other Insured Level Term Rider (complete next page) \$ \_\_\_\_\_
- Monthly Disability Income Rider for Other Insured (complete next page) \$ \_\_\_\_\_ mo. benefit
- Critical Illness Benefit Rider-Other Insured (complete next page) \$ \_\_\_\_\_
- Return of Premium Rider

**WHOLE LIFE INSURANCE**

Face Amount \$ \_\_\_\_\_

If cash value is available, should the Automatic Premium Loan (APL) provision be made effective? (If no option chosen, APL will apply.) .....  Yes  No

**Nonforfeiture Option:** (If no option chosen, ETI will apply)  Extended Term Insurance (ETI)  Reduce Paid-Up Insurance (RPU)

**Dividend Option:** (If no option chosen, PUA will apply)  Paid-up Additions (PUA)  Accumulate at Interest  Reduce Premium/PUA  
 Reduce Premium/Cash  Paid in Cash

**ADDITIONAL BENEFITS AVAILABLE ON WHOLE LIFE—Check benefit(s) desired and indicate amount requested where applicable.**

- Disability Waiver of Premium Benefit Rider
- Monthly Disability Income Rider for Primary Insured \$ \_\_\_\_\_ mo. benefit
- Critical Illness Benefit Rider for Primary Insured \$ \_\_\_\_\_
- Children's Term Insurance Rider (complete next page) \_\_\_\_\_ units
- Level Term Insurance Benefit Rider for Primary Insured (Select only one):  10-Year  20-Year \$ \_\_\_\_\_
- Level Term Insurance Benefit Rider — Other Insured (Select only one):  10-Year  20-Year \$ \_\_\_\_\_
- Payor Benefit Rider (Complete Health Section for Payor) Payor Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  M  F
- Paid-Up Additions Purchase Option (VER)  Periodic Premiums \$ \_\_\_\_\_  Single Premium \$ \_\_\_\_\_
- Protected Insurability Benefit Rider \$ \_\_\_\_\_
- Monthly Disability Income Rider for Other Insured (complete next page) \$ \_\_\_\_\_ mo. benefit
- Critical Illness Benefit Rider-Other Insured (complete next page) \$ \_\_\_\_\_
- Accidental Death Benefit Rider \$ \_\_\_\_\_

**SINGLE PREMIUM WHOLE LIFE INSURANCE**

Face Amount \$ \_\_\_\_\_  Single Premium Insurance Rider \$ \_\_\_\_\_

**Dividend Option:** (If no option chosen, PUA will apply)  Paid-Up Additions (PUA)  Paid in Cash

**LIFE PRODUCT SECTION (continued)**

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

Information	Other Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name <i>(First, Middle, Last)</i>				
Date of Birth <i>(MM/DD/YYYY)</i>	/ /	/ /	/ /	/ /
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
Relationship to Proposed Insured				
Employer and Occupation/Duties	1. Has any proposed insured child <b>ever</b> : a. Been diagnosed with or treated for internal cancer or tumor, lymphoma, leukemia, disorder of the lymph nodes or glandular disorder? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No b. Been diagnosed with or treated for heart disease or disorder? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. During the past <b>5 years</b> , has any proposed insured child been advised by a member of the medical profession to have any diagnostic tests performed but not completed, or for which the results are currently unknown or pending (excluding HIV tests)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  If YES to any of the above, please list child(ren)'s name(s): _____			
Personal Phone No.				
Gross monthly income     \$				
If self-employed, net monthly income     \$				
Has the Other 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 <i>(Not applicable to Child Riders.)</i> If YES, please list type _____ Amount per day _____ Last date of use (MM/DD/YYYY) ____/____/____				
Has the Other Insured ever used any form of marijuana? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No    If YES, please list last date of use (MM/DD/YYYY) ____/____/____				
Is the Other Insured a United States citizen, or does the Other Insured have permanent resident ( <i>green card</i> ) status? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If the Other Insured has permanent resident status, please list permanent resident ( <i>green card</i> ) number. _____ If the Other Insured is not 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? <input type="checkbox"/> Yes <input type="checkbox"/> No    If YES, please list state of issue and number. _____				
Please list the last physician consulted by the Other Insured:                      Is this your primary physician? <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ Date last consulted ____/____/____ <span style="margin-left: 700px;"><i>MM/DD/YYYY</i></span>				
Address _____ <span style="margin-left: 20px;"><i>Street Address</i></span> <span style="margin-left: 150px;"><i>Suite</i></span> <span style="margin-left: 150px;"><i>City</i></span> <span style="margin-left: 100px;"><i>State</i></span> <span style="margin-left: 50px;"><i>ZIP+4</i></span>				
Phone No. (     ) _____ Fax No. (     ) _____				
Reason for consultation _____ Results _____				



## PHYSICIAN INFORMATION

Please list the last physician consulted:

Name \_\_\_\_\_ Date last consulted \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM/DD/YYYY

Address \_\_\_\_\_  
Street Address Suite

City State ZIP+4

Phone No. ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_

Is this your primary physician?  Yes  No

Reason for consultation \_\_\_\_\_

Results \_\_\_\_\_

## AGREEMENT

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

I (We) agree that:

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

**Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law. The falsity of any statement in the application for insurance shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.**

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

Signed at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
City State Date (MM/DD/YYYY)

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Additional Proposed Insured

\_\_\_\_\_  
Signature of Parent/Guardian of Minor Child

\_\_\_\_\_  
Signature of Additional Proposed Insured

\_\_\_\_\_  
Signature of Owner(s) (If other than Proposed Insured)

\_\_\_\_\_  
Signature of Licensed Agent

\_\_\_\_\_  
Print Agent Name and Agent No.





\_\_\_\_\_  
*Legal Name of Applicant/Insured/Claimant (Please print)*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth			
<i>Legal Name</i>	<i>Date of Birth</i>	<i>Legal Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

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.

**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)*

**ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT**



\_\_\_\_\_  
*Legal Name of Applicant/Insured/Claimant (Please print)*

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

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

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth			
<i>Legal Name</i>	<i>Date of Birth</i>	<i>Legal Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

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.

**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)*

**ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT**



\_\_\_\_\_  
*Legal Name of Applicant/Insured/Claimant (Please print)*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth				
<i>Legal Name</i>	<i>Date of Birth</i>	<i>Legal Name</i>	<i>Date of Birth</i>	
_____	_____	_____	_____	
_____	_____	_____	_____	

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:

- Psychotherapy notes

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 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 twelve (12) 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.

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\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*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)*

**ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT**



\_\_\_\_\_  
*Legal Name of Applicant/Insured/Claimant (Please print)*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date of Birth (MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth				
<i>Legal Name</i>	<i>Date of Birth</i>	<i>Legal Name</i>	<i>Date of Birth</i>	
_____	_____	_____	_____	
_____	_____	_____	_____	

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:

- Psychotherapy notes

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 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 twelve (12) 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.

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\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date (MM/DD/YYYY)*

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

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*Signature of Additional Applicant/Insured/Claimant or Legal Representative*

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*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)*

**ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT**

## 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](http://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.









**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 authorization. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
*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

HEMOPHILIA FOUNDATION OF SOUTHERN CALIFORNIA  
Social Services-Southern California  
Hemophilia AIDS Information  
(818) 792-6192  
(714) 740-2222

TTY INFORMATION  
Information and Referral for Hearing Impaired  
(213) 464-0029

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 FOUNDATION  
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



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

**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 Name*

\_\_\_\_\_  
*Date (MM/DD/YYYY)*

**INFORMATION ON POLICIES WHICH MAY BE REPLACED**

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**





**Assurity® 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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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 Name*

\_\_\_\_\_  
*Date (MM/DD/YYYY)*

**INFORMATION ON POLICIES WHICH MAY BE REPLACED**

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**





**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.

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

\_\_\_\_\_  
*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)*

\_\_\_\_\_  
*Signature and Printed Name of Prospective Purchaser's Representative*

\_\_\_\_\_  
*Date (MM/DD/YYYY)*





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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.

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

\_\_\_\_\_  
*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)*

\_\_\_\_\_  
*Signature and Printed Name of Prospective Purchaser's Representative*

\_\_\_\_\_  
*Date (MM/DD/YYYY)*





## 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.**
- **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.

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

\_\_\_\_\_

*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)*

**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.
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_____	_____
<i>Purchaser's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>
_____	_____
<i>Spouse's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>
_____	_____
<i>Legal Representative's Signature and Printed Name</i>	<i>Date (MM/DD/YYYY)</i>



