

PLEASE PRINT WITH BLACK INK

APPLICATION FOR INSURANCE

ASSURITY LIFE INSURANCE COMPANY
1526 K Street, PO Box 80926, Lincoln NE 68501-0926

- New application
Takeover
Addition, increase or change to existing coverage; existing Policy No.

Primary Proposed Insured - Employee

Name (First MI Last), Date of Birth (MM/DD/YYYY), Social Security No., Gender (Male/Female), E-mail, Issue Age, Residential Address, City, State, ZIP, Personal Phone No., Birth State/Country, Height (ft./in.), Weight (lbs.), Employer, Occupation/Title, Duties, Monthly Income \$, Full-Time Hire Date (MM/DD/YYYY), Dept No.

Other Proposed Insured(s) - Dependent(s) (If additional space is needed, attach a separate sheet of paper.)

Table with 4 columns: Name (First MI Last), Relationship to Insured, Date of Birth (MM/DD/YYYY), Issue Age. Includes rows for Spouse and multiple Children.

Beneficiary(ies) (If additional space is needed, attach a separate sheet of paper.)

Table with 3 columns: Name (First MI Last), Relationship to Insured, Date of Birth (MM/DD/YYYY). Includes rows for Primary and Contingent beneficiaries.

For ALL COVERAGES, please answer the following questions.

- 1. During the past 90 days, have you worked less than {30} hours per week in your primary occupation?
2. During the past 90 days, have you been unable to perform any of the duties of your primary occupation?
3. Has any Proposed Insured ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency (AIDS), AIDS Related Complex (ARC) or any immune deficiency disorder?
4. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage?
5. Is there any other life, cancer, heart/stroke, disability, hospital indemnity, critical illness or accident insurance in force or applied for on any Proposed Insureds?



ACCIDENT EXPENSE

Plans	Insured Options	Benefit Options	Riders	Premium Amt
<input type="checkbox"/> 24-hour Accident Exp <input type="checkbox"/> Off-the-job Accident Exp	<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Family	<input type="checkbox"/> 1 unit <input type="checkbox"/> 2 units	<input type="checkbox"/> Short-Term DI Rider <input type="checkbox"/> 6 month benefit <input type="checkbox"/> 12 month benefit <input type="checkbox"/> Other (specify) _____	

Please answer the following questions (only if applying for Short-Term Disability Income Rider).

1. During the past **6 months**, have you missed work for more than 5 consecutive days due to personal injury or illness (except pregnancy)? Yes No



SHORT-TERM DISABILITY INCOME

Plans	Industry Class	Benefit Options	Riders	Premium Amount
<input type="checkbox"/> Accident Only Disability Income <input type="checkbox"/> Accident and Sickness Disability Income	<input type="checkbox"/> Class 1 <input type="checkbox"/> Class 2	Monthly Benefit Amt. \$ _____ Benefit Period: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> 24 months Accident Only Elimination: <input type="checkbox"/> 0 days <input type="checkbox"/> 7 days <input type="checkbox"/> 14 days <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days Accident/Sickness Elimination: <input type="checkbox"/> 0/7 days <input type="checkbox"/> 7/7 days <input type="checkbox"/> 0/14 days <input type="checkbox"/> 14/14 days <input type="checkbox"/> 30/30 days <input type="checkbox"/> 60/60 days <input type="checkbox"/> 90/90 days <input type="checkbox"/> 180/180 days	<input type="checkbox"/> Emergency Acc Rider <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> On-the-Job Disability Income Rider <input type="checkbox"/> Retroactive Injury Benefit Rider <input type="checkbox"/> Spouse Accident Only Disability Income Rider <input type="checkbox"/> Other (specify) _____	

Please answer the following questions.

1. During the past **6 months**, have you missed work for more than 5 consecutive days due to personal illness or injury (except pregnancy)? Yes No

2. During the past **12 months**, has any Proposed Insured been hospitalized, disabled or advised to have diagnostic tests or any medical or surgical procedures by a medical professional that have not been completed or for which results have not been received? **(If YES, please provide details in #5 below.)** Yes No

3. During the past **5 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following: disease or disorder of the heart (including heart attack, heart condition, heart valve disorder), circulatory system, liver, lungs (including emphysema, or Chronic Obstructive Lung or Pulmonary Disease) or kidneys; high blood pressure with reading of 160/100 or higher; hepatitis (other than type A); stroke; Transient Ischemic Attack (TIA); insulin dependent diabetes; cancer (excluding skin); Hodgkin's Disease; leukemia; dementia; Multiple Sclerosis; Muscular Dystrophy; or alcohol or drug abuse? **(If YES, please provide details in #5 below.)** Yes No

4. During the past **5 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had any symptoms of any of the following: disease or disorder of the back, neck, knees, shoulder or joints; carpal tunnel syndrome; chronic fatigue; fibromyalgia; lupus; or asthma (requiring steroids)? **(If YES, please, provide details in #5 below.)** Yes No

5. DETAILS: Enter any details from questions #2-4 below. (If additional space is needed, attach a separate sheet of paper.)

Question #	Name (First MI Last)	Relationship to Insured	Date of Condition (MM/DD/YYYY)	Health Condition & Details	Medical Care Providers' Name/Address/Phone
			/ /		
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California Insurance Law requires that You, the Proposed Insured, are covered by individual or group contract that arranges or provides comprehensive health insurance or HMO plan including medical, hospital and surgical coverage to be eligible to purchase a specified disease policy. Are you, the Proposed Insured, currently insured for comprehensive health care? Yes No IF YOUR ANSWER IS NO, YOU ARE NOT ELIGIBLE TO APPLY FOR THIS POLICY.

CRITICAL ILLNESS

Plan	Insured Options	Benefit Options	Riders	Premium Amt
<input type="checkbox"/> Critical Illness	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Employee Benefit Amt. \$ _____ Spouse Benefit Amt. \$ _____	<input type="checkbox"/> Cancer Benefit Rider <input type="checkbox"/> Wellness Benefit Rider <input type="checkbox"/> Other (specify) _____	

Please answer the following questions.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

- During the past 12 months, has any Proposed Insured used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? Employee: Yes No
Spouse: Yes No
- During the past 12 months, has any Proposed Insured been hospitalized, disabled or advised to have diagnostic tests or any medical or surgical procedures by a medical professional that have not been completed or for which results have not been received? (If YES, please provide details in #9 below.) Yes No
- During the past 10 years, has any Proposed Insured had or been advised to have an organ or tissue transplant, or consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or been diagnosed or treated for any of the following: disease or disorder of the heart (including heart attack, heart condition, congestive heart failure, heart valve disorder), circulatory system (including peripheral vascular disease, carotid artery disease), liver, lungs (excluding asthma but including emphysema, Chronic Obstructive Lung and Pulmonary Disease), kidneys or pancreas; hepatitis (other than type A); stroke; Transient Ischemic Attack (TIA); insulin dependent diabetes; dementia; Alzheimer's Disease; paralysis; multiple sclerosis; muscular dystrophy; alcohol or drug abuse? (If YES, please provide details in #9 below.) Yes No
- During the past 6 months, has any Proposed Insured been diagnosed or treated for any blood pressure readings of 160/100 or higher? (If YES, please provide details in #9 below.) Yes No
- During the past 10 years, has any Proposed Insured needed assistance or personal supervision to perform any activities of daily living (toileting, transferring, continence, eating, bathing, or dressing)? (If YES, please provide details in #9 below.) Yes No
- If applying for a Benefit Amount above \$30,000: Have any two or more of the Proposed Insured's natural parents or siblings, either living or deceased, ever consulted with or been diagnosed, treated or prescribed medication by a medical professional before the age of 60 for the same condition from the following list: disease or disorder of the heart (including heart attack, heart condition, heart valve disorder), kidney disease, stroke, diabetes, cancer or Alzheimer's Disease? (If YES, please provide details in #9 below.) Yes No
- If applying for the Cancer Rider: During the past 10 years, has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for internal cancer, leukemia, lymphoma, Hodgkin's Disease, melanoma, malignant tumors or carcinoma in situ? (If YES, please provide details in #9 below.) Yes No
- If applying for the Cancer Rider: During the past 12 months, has any Proposed Insured been hospitalized, disabled or advised to have diagnostic tests or any medical or surgical procedures by a medical professional that have not been completed or for which results have not been received? (If YES, please provide details in #9 below.) Yes No

9. DETAILS: Enter any details from questions #2-8 below. (If additional space is needed, attach a separate sheet of paper.)

Question #	Name (First MI Last)	Relationship to Insured	Date of Condition (MM/DD/YYYY)	Health Condition & Details	Medical Care Providers' Name/Address/Phone
			/ /		



Primary Proposed Insured's Agreement

I have read the answers and statements written in this application, and represent each and all of them to be true and complete to the best of my knowledge and belief. In the absence of fraud, my answers in this application shall be deemed representations and not warranties. I agree that a copy of this application and any supplement shall be attached to and form a part of any policy issued. Acceptance of any insurance policy issued on this application as evidenced by the payment of premiums, will constitute a ratification of any corrections or additions to the application noted by Assurity in the space headed "HOME OFFICE CORRECTIONS OR ADDITIONS ONLY" for administrative purposes. A photocopy of the amended application attached to the policy will be sufficient notice to me of such corrections or additions.

The insurance applied for shall be in force as of the policy issue date as shown on the policy schedule and not the date the application is signed. I understand that any premiums deducted before the issue date of the policy(ies) are pre-paid premiums and will be applied to coverage beginning on the issue date. If the policy(ies) is(are) not issued, Assurity will refund any premium deductions it receives.

HOME OFFICE CORRECTIONS AND ADDITIONS ONLY

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

Issue Date _____

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

Primary Proposed Insured's Signature _____

Payor's Signature (for Term Life only) _____

Agent's Statement and Agreement

I hereby certify that I have accurately recorded in this application all information supplied by the Proposed Insured. The Proposed Insured has read the completed application, or has had the completed application read to them. I also certify that this insurance does does not replace or change any existing life, health or annuity coverage.

Agent's Printed Name _____ Agent No. _____ Agent's Telephone No. _____

Agent's Signature _____ on _____
 (Date MM/DD/YYYY)

Group No. _____



Primary Proposed Insured Name _____

ELIMINATION AND AMENDMENT OF BENEFITS

RIDER ISSUE DATE (same as Policy Issue Date if no date shown) _____

In consideration of the issuance of the Policy to which this Rider is attached, it is hereby understood and agreed that the persons named in the application as having a condition listed below prior to the date the application was signed, are excluded from coverage as indicated below:

Elimination of Benefits

- a. Skin Cancer
Assurity Life Insurance Company will not be liable for any loss resulting from skin cancer affecting

Name(s)
for a period of 2 years from the Rider Issue Date. Coverage for anyone excluded under this section is limited to loss resulting from any cancer other than skin cancer.

- b. Specified Diseases Rider
Assurity Life Insurance Company will not be liable for any loss resulting from

Specified Disease(s)
affecting _____,
Name(s)
which is excluded from coverage for the named Specified Disease(s).

- c. Intensive Care Unit Rider
Assurity Life Insurance Company will not be liable for any benefits under the Intensive Care Unit Rider for

Name(s)
for loss resulting from any disease or disorder of the heart, stroke or diabetes. Furthermore, the intensive care benefits for such person will be limited to 3 days in connection with any one period of confinement for any other injuries or sickness, not the 30 days as stated in the Intensive Care Unit Rider.

Amendment of Benefits

- d. All Cancers including malignant melanomas and carcinoma in situ
Assurity Life Insurance Company is amending coverage to show

Name(s)
is excluded from coverage under this policy and any attached riders.

Amendment of Benefits for All Other Plans

- e. Removal of an Individual
Assurity Life Insurance Company is amending coverage to show

Name(s)
is excluded from coverage under this policy and any attached riders

- f. Removal of a Benefit Rider
Assurity Life Insurance Company is amending coverage to show that no benefits are available under

Rider Name and Form Number
for _____
Name(s)

Accepted by _____ on _____
Primary Proposed Insured (Employee) (Date MM/DD/YYYY)

