PLEASE PRINT WITH BLACK INK

APPLICATION FOR INSURANCE

ASSURITY LIFE INSURANCE COMPANY
1526 K Street, PO Box 82533, Lincoln NE 68501-2533

☐ 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. - -	☐ 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.)

Name (First MI Last)			Relationship to Insured	Date of Birth (MM/DD/YYYY)	Issue Age
	Height ft. in.	Weight lbs.	Spouse	/ /	
			Child	/ /	
			Child	/ /	
			Child	/ /	
			Child	/ /	

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

	Name (First MI Last)	Relationship to Insured	Date of Birth (MM/DD/YYYY)
Primary			/ /
Contingent			/ /

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? .... ☐ Yes ☐ No
2. During the past **90 days**, have you been unable to perform any of the duties of your primary occupation? .... ☐ Yes ☐ No
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? .... ☐ Yes ☐ No
   If YES, identify name(s) of person(s) ____________________
4. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? .... ☐ Yes ☐ No
   If YES, complete replacement form provided by your agent if required by your state.
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? .... ☐ Yes ☐ No
   If YES, list person, company name, policy number, year issued, type of coverage and amount of benefit.
   ____
   ____
   ____

Primary Proposed Insured Name ______________________

ACCIDENT EXPENSE

Plans	Insured Options	Benefit Options	Riders	Premium Amt
☐ 24-hour Accident Exp ☐ Off-the-job Accident Exp	☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Family	☐ 1 unit ☐ 2 units	☐ Short-Term DI Rider ☐ 6 month benefit ☐ 12 month benefit ☐ 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

Primary Proposed Insured Name ____________________

SHORT-TERM DISABILITY INCOME

Plans	Industry Class	Benefit Options	Riders	Premium Amount
☐ Accident Only Disability Income ☐ Accident and Sickness Disability Income	☐ Class 1 ☐ Class 2	Monthly Benefit Amt. $ ________ Benefit Period: ☐ 3 months ☐ 6 months ☐ 12 months ☐ 24 months	☐ Emergency Acc Rider ☐ $100 ☐ $150 ☐ $200 ☐ On-the-Job Disability Income Rider ☐ Retroactive Injury Benefit Rider ☐ Spouse Accident Only Disability Income Rider ☐ Other (specify) ____________	

Accident Only Elimination: ☐ 0 days ☐ 7 days ☐ 14 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Accident/Sickness Elimination: ☐ 0/7 days ☐ 7/7 days ☐ 0/14 days ☐ 14/14 days ☐ 30/30 days ☐ 60/60 days ☐ 90/90 days ☐ 180/180 days

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
			/ /		
			/ /		
			/ /		
			/ /		

Primary Proposed Insured Name ____________________

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
☐ Critical Illness	☐ Employee ☐ Spouse ☐ Child	Employee Benefit Amt. $__________ Spouse Benefit Amt. $__________	☐ Cancer Benefit Rider ☐ Wellness Benefit Rider ☐ 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.

1. 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

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 #9 below.)**.... ☐ Yes ☐ No

3. 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

4. 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

5. 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

6. 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

7. **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

8. **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 Name ____________________

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)