



Toll Free: 1-800-276-7619, Ext. 4264

AssureLINK Address: <http://assurelink.assurity.com>

## Pennsylvania Application for Disability Income Insurance

This application includes all forms needed to apply for Disability Income Insurance.

This application does not include the Life or Critical Illness section(s).

Thank you for your interest in writing business with Assurity Life Insurance Company.

**You may write a Life or Critical Illness application\* in combination with this Disability Income application. In addition to this application, simply complete the appropriate Life or Critical Illness section(s) obtained from AssureLINK or from a Life or Critical Illness application. The advantages of writing a combined application are:**

- answer medical questions once
- reviewed by Underwriting once
- scheduling one medical exam
- achieve two/three sales with one visit

To enable us to process your application more quickly, please review the following checklist:

- ✓ For Disability Income and Critical Illness products, the application should coincide with the **state in which the policy Owner resides** for the states listed below. (For Disability applications, the Proposed Insured and the policy Owner must be the same person.)

Disability Income (Form A-D109): CA, FL

Simplified Critical Illness (Form CI 005): AR, CO, FL, ID, ME, MN, MT, NH, NC, ND, OK, PA, UT, WV

Critical Illness (Form CI 007): AR, ID, ME, MT, NC, ND, OK, PA, UT, WV

All other applications should coincide with the **state where the application is signed**. State specific applications and state forms can be found on AssureLINK.

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state coinciding with the application used**.
- ✓ Print the application in black ink for faxing and photocopying purposes.
- ✓ Please verify that all questions on the application are answered. 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
  1. NAIC Model Illustration or disclosure statement must accompany any whole life application.
  2. 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 QUESTIONS RELATING TO UNDERWRITING (INCLUDING "WHAT IF" SCENARIOS) CALL TOLL FREE 800-276-7619, EXT. 4264 OR EMAIL TO [underwriting@assurity.com](mailto:underwriting@assurity.com).**



**1. PROPOSED INSURED**

|                                                                                                                                                                                                    |                                                               |                                         |                                             |                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------|---------------------------------------------|--------------------------------------------------|
| Legal Name<br><i>First Middle Last</i>                                                                                                                                                             |                                                               |                                         | Date of Birth<br><i>(MM/DD/YYYY)</i><br>/ / |                                                  |
| Social Security No.                                                                                                                                                                                | <input type="checkbox"/> Male <input type="checkbox"/> Female | E-mail                                  |                                             | Age                                              |
| Home Address<br><i>Street Address</i>                                                                                                                                                              |                                                               | <i>City</i>                             | <i>State</i>                                | <i>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) / /                                                                                                                        |                                                               |                                         |                                             |                                                  |
| 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.                                                                                |                                                               |                                         |                                             |                                                  |
| 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<br><i>Years Months</i><br>/ |
| Primary Employer                                                                                                                                                                                   | Employer's Address<br><i>Street Address City State ZIP+4</i>  |                                         |                                             |                                                  |
| Full-time Employment<br><i>Occupation Duties</i>                                                                                                                                                   | Part-time Employment<br><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 form rather than this section.

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

**3. BENEFICIARIES (Do not complete if applying for Reversionary Annuity coverage)**

If Beneficiary is a trust, or if additional space is needed, complete the Trust Information/Additional Beneficiary form.

| 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:

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

## GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? .....  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 contemplating flying as a pilot, crew member or student? .....  Yes  No

b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? .....  Yes  No

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

3. During the next **12 months**, does any Proposed Insured contemplate residence 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 reason for change:  
 \_\_\_\_\_

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

a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? .....  Yes  No

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

b. 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 had more than 3 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. a. Is other insurance coverage in force for any Proposed Insured? .....  Yes  No

If YES, please 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 or health coverage, please complete and return the appropriate State Replacement Form.

| Insured's Name | Company Name | Policy No. | Individual (I)<br>Group (G)                           | Benefits ( <i>monthly benefit and benefit period for DI or face amount for Life</i> ) | Issue Date<br>(MM/DD/YYYY) | DI Coverage Only                                         |                                                          |
|----------------|--------------|------------|-------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------|----------------------------------------------------------|
|                |              |            |                                                       |                                                                                       |                            | Coordinates w/<br>Soc. Sec.?                             | Employer Paid?                                           |
|                |              |            | <input type="checkbox"/> I <input type="checkbox"/> G |                                                                                       | / /                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                |              |            | <input type="checkbox"/> I <input type="checkbox"/> G |                                                                                       | / /                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                |              |            | <input type="checkbox"/> I <input type="checkbox"/> G |                                                                                       | / /                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

10. **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. If YES to any of the following, please provide details on page 2.

1. During the past **5 years**, has any Proposed Insured consulted with or 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 abnormal 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, 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 lymph nodes or any glandular disorder? .....  Yes  No
  - d. Alzheimer's disease, dementia, memory loss, seizures, mental retardation (*including Down's 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, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder (*lupus or scleroderma*)? .....  Yes  No
  - f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? .....  Yes  No
  - g. Arthritis, rheumatism 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? .....  Yes  No
  - j. Any other illness or injury requiring medical attention or blood transfusions? .....  Yes  No

2. 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. 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 by a physician, or advised by a physician to seek treatment, for drug or alcohol use? .....  Yes  No
  - d. Been advised to have any test (*except HIV tests*), treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which results have not been received?.....  Yes  No
  - e. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related blood tests*) or urine tests? .....  Yes  No

3. During the past **5 years**, has any Proposed Insured been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*); or had a positive test for human immunodeficiency virus (*HIV*) antibodies? .....  Yes  No

4. Has any Proposed Insured had a natural parent or sibling who was diagnosed with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death. ....  Yes  No  
 \_\_\_\_\_

5. a. During the past **5 years**, has any Proposed Insured had any disorder of any genital or reproductive organ, or had 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) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**DETAILS:** Enter complete details from questions #1-5 on page 2. If more space is needed, attach additional Supplemental Information form.

**SUPPLEMENTAL INFORMATION**

| Question #/Letter | Name<br>(First, Middle, Last) | Onset Date<br>(MM/DD/YYYY) | Duration<br>(Days, Mos, Yrs) | Health Condition<br>and Details | Medical Care Provider's<br>Name/Address/Phone |
|-------------------|-------------------------------|----------------------------|------------------------------|---------------------------------|-----------------------------------------------|
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |
|                   |                               | / /                        |                              |                                 |                                               |

**Additional Information:**

**Home Office Use Only**



## DISABILITY INCOME PRODUCT SECTION

Please complete for either Personal Disability Income or Business Overhead Expense Disability Income.

Survivor Benefit Beneficiary Name \_\_\_\_\_  
*First*
*Middle*
*Last*

Relationship to Insured \_\_\_\_\_ Date of Birth (MM/DD/YYYY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### PERSONAL DISABILITY INCOME

Monthly Base Amount \$ \_\_\_\_\_ Occupation Class:  4 A  3 A  2 A  1 A

Elimination Period:  30 days  60 days  90 days  180 days  365 days

Benefit Period:  1 Year  2 Years  5 Years  10 Years  To age 65  To age 67

#### ADDITIONAL BENEFITS (If available)

Check benefit(s) desired and indicate amount requested.

Supplemental Disability Income Rider \$ \_\_\_\_\_  Guaranteed Insurability Rider  Residual Disability Benefit Rider

Other (Specify) \_\_\_\_\_ \$ \_\_\_\_\_  Automatic Benefit Increase Rider  Non-Cancelable Rider

Other (Specify) \_\_\_\_\_ \$ \_\_\_\_\_  Retroactive Injury Benefit Rider  Return of Premium Benefit Rider

5-Year Own Occupation Rider (not available with 1 or 2-Year Benefit Period)

10-Year Own Occupation Rider (available with 10-Year Benefit Period)

To Age 65 Own Occupation Rider (available with To Age 65 Benefit Period)

To Age 67 Own Occupation Rider (available with To Age 67 Benefit Period)

Catastrophic Disability Benefit Rider (Select desired Benefit Period for Catastrophic Disability Benefit Rider.)

Available with 1-Year Base Benefit Period:  4-Year Rider Benefit Period OR  9-Year Rider Benefit Period

Available with 2-Year Base Benefit Period:  3-Year Rider Benefit Period OR  8-Year Rider Benefit Period OR  To Age 65 Benefit Period

Available with 5-Year Base Benefit Period:  5-Year Rider Benefit Period OR  To Age 65 Benefit Period

Available with 10-Year Base Benefit Period:  To Age 65 Benefit Period

### BUSINESS OVERHEAD EXPENSE DISABILITY INCOME

Monthly Base Amount \$ \_\_\_\_\_ Occupation Class:  4 A  3 A  2 A

Elimination Period:  30 days  60 days  90 days

Benefit Period:  1 Year  2 Years

#### Average monthly expenses currently incurred, for which the Proposed Insured is liable:

| Type of Expense                                   | Monthly Amount | Type of Expense                       | Monthly Amount  |
|---------------------------------------------------|----------------|---------------------------------------|-----------------|
| Employees' salaries                               | \$ _____       | Accounting fees                       | \$ _____        |
| Utilities (electricity, gas, water, telephone)    | \$ _____       | Property/payroll taxes                | \$ _____        |
| Business space (rent/mortgage payment)            | \$ _____       | Other eligible expenses (Please list) |                 |
| Furniture/equipment payments (lease or principal) | \$ _____       | _____                                 | \$ _____        |
| Laundry, office maintenance                       | \$ _____       | _____                                 | \$ _____        |
| Business insurance premiums                       | \$ _____       | _____                                 | \$ _____        |
|                                                   |                | <b>Total Monthly Expenses</b>         | <b>\$ _____</b> |



## PHYSICIAN INFORMATION

Please list the last physician seen:

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 (excluding AIDS or ARC) \_\_\_\_\_

Results (excluding AIDS or ARC) \_\_\_\_\_  
\_\_\_\_\_

## 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 continued good health and the life and continued good health of any other person(s) covered under the policy. 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.

**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 subjects such person to criminal and civil penalties.**

**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 \_\_\_\_\_  
City State

on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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 Beneficiary (If applying for Reversionary Annuity)

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

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



**FIELD UNDERWRITER'S STATEMENT**

- 1. a. What amount was collected with this application? \$ \_\_\_\_\_
b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ... Yes No
c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ... Yes No
2. a. Did you personally see all Proposed Insured(s) on the date of application? ... Yes No
b. How well do you know the Proposed Insured(s)? Well Slightly Not at all
c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? If YES, please provide details below. ... Yes No
3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ... Yes No
Agent is responsible for scheduling exam items.
NOTE: ANY PREFERRED PLANS REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.
Paramedical examination Blood Sample Urine Sample Electrocardiogram (EKG) Treadmill EKG Medical exam by physician
4. Is other insurance coverage in force for any Proposed Insured? ... Yes No
5. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ... Yes No
6. Was sales material used in soliciting this application? ... Yes No
7. Was the sales material left with the applicant? ... Yes No
8. Was the sales material approved by Assurity Life Insurance Company? ... Yes No
9. Are commissions to be split? Yes No Agent No. % Agent No. %

**AUTOMATIC PAYMENT OPTIONS**

- Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.
Add to existing bank withdrawal—indicate other applicant and/or policy numbers
Set up NEW credit card payment—submit signed authorization with the application.

**LIST BILL**

- Set up NEW list bill— submit signed authorization with the application.
Add to existing list bill; indicate list bill no. and/or name of company

**FOR TERM LIFE APPLICATION**

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

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

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

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

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

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

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

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

Signature of Soliciting Agent Date (MM/DD/YYYY) Business Phone No. and Fax No.
Soliciting Agent's Printed Name Agent No. Agent's E-mail





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

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

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

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

| Applicant/Insured/Claimant Child(ren) |               |       |               |
|---------------------------------------|---------------|-------|---------------|
| Name                                  | Date of Birth | Name  | Date of Birth |
| _____                                 | _____         | _____ | _____         |
| _____                                 | _____         | _____ | _____         |

I, on behalf of myself or the person named above (*Individual*), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company (*Assurity*), its reinsurers and/or consumer reporting agencies and their authorized representatives (*provided, however, consumer reporting agencies may not collect information under this authorization from the MIB*):

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation*), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus (*HIV*) infection and sexually transmitted diseases (**Except information about human immunodeficiency virus (*HIV*) infection for Individuals residing in Maine or Vermont.** **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (*MIB*), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four (24) months from the date of signature below (**Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below**), for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

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

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

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

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

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





## 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 MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

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

**EXAMINER:** \_\_\_\_\_

*Name*

*Address*

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 insurance.

Due to the serious nature of HIV-related illnesses, you may wish to obtain counseling, at your expense, prior to undergoing the HIV-related test.

Information regarding alternative HIV-related testing and counseling is provided by the Pennsylvania Department of Health and by local health departments. You may secure additional information on testing and counseling from the Department of Health at 717-783-0479.

Unless precluded by law, tests may be performed to determine the presence of antibodies 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 HTLV-III—Western Blot Test Protocol helps to identify AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (*fats*) and screening for liver or kidney disorders, diabetes and immune disorders.

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 Medical Information Bureau (*MIB, Inc.*) and if the test results for HIV antibodies are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only nonspecific blood and/or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. 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 authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. You may request notification of negative HIV test results. If the HIV test results are other than normal, the Insurer will contact the physician; Pennsylvania Department of Health; local health department; or community-based organization (*from a list prepared by the Pennsylvania Department of Health*), whichever you designate.

Your consent may be revoked at any time except to the extent the Insurer making a disclosure has acted in reliance on your consent.

Positive HIV antibody 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 have concluded that persons who are HIV antibody-positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody test 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. However, no exclusion rider or endorsement will be applied.

I have read and I understand this Notice of Consent for Blood Testing Which May Include HIV Antibody Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood and the disclosure of the test/screening 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.

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

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

I understand that I have the right to request and receive notification of negative HIV test results.



In the event of a positive HIV test result, I authorize Assurity Life Insurance Company to send the test results to the following health care professional for post-test counseling and for Health Department reporting purposes:

Name and address of physician; the Pennsylvania Department of Health; local health department; or community-based organization *(from the list prepared by the Pennsylvania Department of Health)*, whichever you designate to receive notice of a positive result:

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Proposed Insured (please print)*

\_\_\_\_\_  
*State of Residence*

\_\_\_\_\_  
*Signature of Proposed Insured or Parent/Guardian*

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

### **LOCAL COMMUNITY-BASED ORGANIZATIONS**

Pittsburgh AIDS Task Force  
141 South Highland Avenue  
Pittsburgh, PA 15206  
412-363-2437

Philadelphia Community Health Alternatives  
1642 Pine Street  
Philadelphia, PA 19103  
215-735-1911

Congreso-de Latinos Unidos, Inc.  
Programa Esfurizo  
704 West Girard Avenue  
Philadelphia, PA 19103  
215-228-3880

BEBASHI  
5205 North Broad Street  
Philadelphia, PA 19141  
215-546-4140





**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application (*information you have furnished*), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Assurity Life Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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

After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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

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

\_\_\_\_\_ *Applicant's Signature and Printed Name*

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





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