Toll Free: **1-800-276-7619, Ext. 4264**
Extranet Address: **http://info.assurity.com**

Colorado 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 the **Extranet** 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 the Extranet.

✓ 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 (402) 437-4591.
If emailing an application directly to the Home Office, email to appsubmit@assurity.com.

✓ 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.

Insurance Application to Assurity Life Insurance Company

PART 1 – General Section – Knowingly providing false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud is unlawful. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or its agent that knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant regarding amounts payable from insurance proceeds for the purpose of defrauding or attempting to defraud shall be reported to the Colorado Department of Regulatory Agencies, Division of Insurance.

I hereby apply for insurance with Assurity Life Insurance Company to be issued in reliance upon the following statements which I represent to be complete and true to the best of my knowledge and belief:

1. A. Full First Name (Please Print) Middle Initial Last Name			B. Social Security #	C. Sex ☐ M ☐ F
D. Date of Birth Mo. Day Year / /	E. Age Nearest birthday	F. Height Weight _____ _____	G. Weight change in past year _____ lbs. ☐ loss ☐ gain	H. Birth State
2. A. Residence: Street and No. _____ _____		City	State	Zip Code
B. Proposed Insured's home phone number		Best time to call Proposed Insured		
3. A. Occupation and duties (including those pertaining to any part-time occupation) Occupation: Duties:		B. Employer and address _____ _____ _____ C. How long employed?	D. Gross average Monthly income (if not self-employed) If self-employed, net monthly income:	

4. Do you belong to any National Guard or military? ……. ☐ Yes ☐ No
   If "yes," please explain: _____
5. Has any person to be covered flown during the last 5 years as a pilot, student pilot or crew member? ☐ Yes ☐ No
   If "yes," please complete the Avocation Questionnaire
6. Has any person to be covered participated during the last 3 years in any hazardous sports or activities such as motor vehicle or boat racing, sky diving, skin or scuba diving or any such related activities? ☐ Yes ☐ No
   Are any such activities contemplated? …… ☐ Yes ☐ No
   If "yes," please complete the Avocation Questionnaire.
7. Do you contemplate residence or travel outside of the United States for more than 60 days within the next year? …… ☐ Yes ☐ No
   If "yes," please explain: _____
8. Within the last 5 years, have you or to your knowledge has any person to be covered:
   A. Had life, health, or hospital expense insurance postponed, rated up, ridered, declined or had renewal or reinstatement refused? …….. ☐ Yes ☐ No
   B. Received benefit payments for accident or sickness or applied to any government or insurance organization for such benefits? …… ☐ Yes ☐ No
   If either A or B is answered "yes," please explain: _____
   _____
9. If this insurance is issued, will it replace any insurance, annuity or other policy? …… ☐ Yes ☐ No
   If "yes," please complete: Policy Number: _____
   Name and address of company being replaced _____
   (Send the State replacement forms with application.)
10. Are you negotiating for other insurance coverage? ……. ☐ Yes ☐ No
    If "yes," please explain: _____
11. Has the Proposed Insured ever used any form of tobacco or nicotine-based products? ……. ☐ Yes ☐ No
    If "yes," when did the Proposed Insured last use tobacco or nicotine-based products? Date: _____
12. Driver's license number: _____
    Has any person to be covered received any citations within the last 5 years for motor vehicle moving violations or had a driver's license suspended or revoked? ……. ☐ Yes ☐ No
    If "yes," please explain: _____

Part 1 – General Section (Cont.) If medical exam required due to age and/or amount, you may omit answering questions 14-19 on Proposed Insured.

13. Names of dependent Children (who have not reached their 19th birthday) proposed for Children's Term Insurance Rider. ***(Note: Please complete 14-17 for any children to be covered.)***

Full Name	Relationship	Birthdate	Age	Height	Weight lbs.	Residing w/ Insured	Name/Address of Physician
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

14. Have any persons to be covered ever been treated for, been hospitalized for, or been positively diagnosed by a member of the medical profession as having any of the following? *If "yes", complete #16 below.*

A. Dizziness, fainting spells, epilepsy, depression, anxiety, mental disorder, or any disease or disorder of the brain or nervous systems? …….. ☐ Yes ☐ No
B. Asthma, bronchitis, tuberculosis, pneumocystis, or any disorder of the lungs or respiratory system? ☐ Yes ☐ No
C. High blood pressure, chest pain, shortness of breath, heart murmur, rheumatic fever or any disease or disorder of the heart, hemophilia or coagulation disorder? …… ☐ Yes ☐ No
D. Any disease or disorder of the stomach, intestines or bowel, rectum, appendix, liver or gall bladder? ☐ Yes ☐ No
E. Any disease or disorder of the kidney, bladder or prostate? …… ☐ Yes ☐ No
F. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints, or muscles? ….. ☐ Yes ☐ No
G. Diabetes, or sugar, albumin or blood in the urine? …….. ☐ Yes ☐ No
H. Cancer or a tumor or cyst of any kind, or enlargement of lymph nodes? …… ☐ Yes ☐ No
I. Varicose veins, varicose ulcer or phlebitis, syphilis, or a hernia? …… ☐ Yes ☐ No
J. Any disease or disorder of the eyes, ears, nose or throat? …… ☐ Yes ☐ No
K. Any advice or treatment for alcoholism, drug addiction, drug abuse or other substance abuse? ….. ☐ Yes ☐ No
L. Have you ever received medical diagnosis of, or tested positive for AIDS (Acquired Immunological Deficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder?…… ☐ Yes ☐ No
M. Any other illness or injury requiring blood transfusion or other medical attention? …… ☐ Yes ☐ No
N. Any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests other than AIDS related blood tests, or urine tests during the past 5 years? …… ☐ Yes ☐ No

15. Answer only if applying for the Catastrophic rider on your Disability Income application.
Have you ever needed assistance or personal supervision to perform any Activities of Daily Living (toileting, transferring, continence, eating, bathing, or dressing)? If "yes", please explain below in question #16. ☐ Yes ☐ No

16. If any questions in 14 are answered "yes," indicate the question number and give complete details. **If additional space is required, attach a separate page signed by the Proposed Insured.**

No.	Name of Person	Condition	Onset Date	Duration	Names, Addresses and Phone #'s of all Physicians, Hospitals and Medical Facilities

17. Name, address, phone and fax # of Proposed Insured's regular physician:	Date last consulted:
Fax: Phone:	Reasons and results:

18. Family History: Has any of your immediate family members (parents, brothers, or sisters) died from cancer, diabetes or cardiovascular disease prior to age 60?…… ☐ Yes ☐ No
If "yes," identify family member, disorder, and age at death below:

_____

_____

19. A. Has any person to be insured had any disorder of any genital or reproductive organ; or a miscarriage, stillbirth or Cesarean section?…… ☐ Yes ☐ No
B. Is any person to be insured now pregnant? If "yes," give date child is expected: _____ ☐ Yes ☐ No

PART 1 – DISABILITY SECTION

20. If the Proposed Insured were to become disabled, what amount of income or benefits would be received from: **1)** Individual Disability Income Policy, **2)** Sick Pay Plan and Salary Continuation Plans, **3)** Group Long and Short Term Disability Coverage, **4)** Business Overhead Expense, and **5)** Credit Disability Insurance. **If "None," so state.**

Company or Source	Type 1-5 (above)	Monthly Amount	Elimination Period	Benefit Period	Coordinates with Social Security?	Employer Paid?
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N
					☐ Y ☐ N	☐ Y ☐ N

21. Disability Plan _____
Monthly Income Base Amount $_____ Occupation Class _____ ☐ Tobacco ☐ Non-Tobacco
Elimination Period: ☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365 Days Benefit Period: ☐ 1 year ☐ 2 years ☐ 5 years ☐ To age 65

OPTIONAL BENEFITS/RIDERS

Supplemental Disability Income Rider $_____ Guaranteed Insurability _____ Units
☐ Hospital Benefit ☐ Non-cancellable ☐ 5-Year Own Occupation ☐ Automatic Increase
☐ Residual Benefit ☐ Return of Premium ☐ Other _____
☐ Catastrophic Disability (Select desired Benefit Period for Catastrophic Disability 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
Available with 5 year Base Benefit Period: ☐ 5 Year Rider Benefit Period

22. Who should receive Survivor Benefits? Name _____ Relationship _____

BUSINESS OVERHEAD EXPENSE DISABILITY

23. Monthly Income Base Amount $_____ Occupation Class _____ ☐ Tobacco ☐ Non-Tobacco
Elimination Period ☐ 30 ☐ 60 ☐ 90 Days Benefit Period ☐ 12 months ☐ 24 months

24. Average monthly expenses currently incurred, for which Proposed insured is liable.

Employee's Salaries	$ _____	Business Insurance Premiums	$ _____
Utilities (Electricity, Gas, Water, Telephone)	$ _____	Accounting Fees	$ _____
Business Space (Rent or Mortgage Payment)	$ _____	Property and Payroll Taxes	$ _____
Furniture, Equipment Payments (Lease or Principal)	$ _____	Other Eligible Expenses (please list) _____	$ _____
Laundry, Office Maintenance	$ _____	_____	$ _____
		TOTAL MONTHLY EXPENSES	$ _____

25. How shall premiums be payable? ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ PAC ☐ Other _____

I AGREE THAT

A. I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree that this application (Part 1—General Section, pages 1 and 2 and Part 1—Disability Section, and Answers Made to the Medical Examiner if required) shall form a part of the policy if attached thereto.

B. 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 Conditional Receipt delivered by the Company's agent in exchange for such payment.

C. 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 the application is approved by the Company at its Home Office, such policy issued and delivered to Proposed Insured/Owner, and such first full premium paid during the Proposed Insured's lifetime and continued good health, and 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.

D. No agent or medical examiner has power or is authorized to change or waive any term, provision or condition of this application, the Conditional Receipt, or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Signed at _____ this_____ day of _____ , Year _____ .

Witnessed by _____ _____
Licensed Resident Agent Signature of Proposed Insured

Agency No _____

Field Underwriter's Statement

1. A. What amount was collected with this application? $ _____
   B. Has a Conditional Receipt been given to the Proposed Insured/Owner? ..... ☐ Yes ☐ No
   C. Has an Authorization for Release of Medical Information been signed and Fair Credit and M.I.B. notification been given? ..... ☐ Yes ☐ No
2. A. Did you personally see all persons to be insured on date of application? ..... ☐ Yes ☐ No
   If "No," please explain in #7.
   B. How well do you know Proposed Insured? ☐ Well ☐ Slightly ☐ Relative ☐ 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? ..... ☐ Yes ☐ No
   If "Yes," please explain in #7.
   D. Is the Proposed Insured a citizen of the United States? ..... ☐ Yes ☐ No
   If "No," provide type of visa, number, and expiration date below:
   _____
3. Is application being submitted on a non-medical basis? ..... ☐ Yes ☐ No
   If "No," check items for which arrangements have been made:
   ☐ Medical exam by physician with Home Office specimen ☐ Blood Profile ☐ EKG ☐ Chest X-ray
   ☐ Paramedical examination with Home Office specimen* ☐ Dried Blood Profile ☐ Blood Profile ☐ EKG
   *Preferred Plus and Preferred underwriting classifications require blood profile, not dried blood spot.

   Name and address of examiner _____
   Date above items to be completed _____
4. All Life cases require a signed illustration be submitted with the application or a signed Illustration Disclosure Statement. The Premiums for this application were quoted on the following underwriting classification:
   ☐ Preferred Plus ☐ Preferred ☐ Select (standard, non-tobacco) ☐ Tobacco
5. If this insurance is issued, will it replace any insurance, annuity or other policy? ..... ☐ Yes ☐ No
   If "Yes," I also confirm that this Replacement is in accordance with the Company's position on Replacement cases. (See the reverse side of the Application coverage page.)
6. 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.

   _____ _____ Date _____ Year _____
   Soliciting Agent Signature — Code No.

   _____ _____ _____
   Soliciting Agent Printed Name — Agent Business Phone # — Agent Fax #

   Agent E-mail Address: _____

7. Special requests, remarks and instructions:
8. **Referrals** Name: _____
   Name: _____

Was this application faxed to the Home Office? ☐Yes ☐No
If yes, date faxed _____

9. ☐ Pre-Authorized Check (PAC) – Special monthly rate is 8.8% of annual premium.
   ☐ New PAC – Signed authorization and deposit ticket needed with application. Applications and/or policy numbers _____ to be included on this PAC.
   ☐ Add to existing PAC on: _____
   _____
   ☐ List Billing – Set up new list billing—complete Employer's Authorization and Case Agreement (form VBDIEA-97)
   ☐ List Billing _____ – Add to existing billing # _____ to:

Name of Company _____
_____

For Home Office use only: Date received _____ Policy # _____ CWA $ _____

ASSURITY LIFE INSURANCE COMPANY
1526 K STREET ● PO BOX 82533 ● LINCOLN, NEBRASKA 68501-2533 ● TOLL FREE 800-276-7619, EXT. 4264

AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL MEDICAL INFORMATION

Name of Proposed Insured ("Applicant")_____

I, on behalf of myself or the person named above ("Applicant"), 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, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Assurity") or its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from 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.
- Information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Applicant 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 Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant'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 when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information.

This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. 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 understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Applicant to obtain treatment. 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.

I acknowledge receipt of notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under the law.

_____

Signature of Proposed Insured or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Insured _____

ASSURITY LIFE INSURANCE COMPANY
1526 K STREET ● PO BOX 82533 ● LINCOLN, NEBRASKA 68501-2533 ● TOLL FREE 800-276-7619, EXT. 4264

AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL MEDICAL INFORMATION

Name of Proposed Insured ("Applicant")_____

I, on behalf of myself or the person named above ("Applicant"), 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, employer or other organization or person that has any records or knowledge of me or my 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 MIB):

- Psychotherapy notes.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Applicant 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 Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire psychotherapy notes 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 when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information.

This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. 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 understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Applicant to obtain treatment. 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.

I acknowledge receipt of notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under the law.

_____

Signature of Proposed Insured or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Insured _____

ASSURITY LIFE INSURANCE COMPANY
1526 K Street • PO Box 82533
Lincoln, NE 68501-2533
Toll Free 800-276-7619, Ext. 4264

Notice of Investigative Consumer Report
Required by the
Fair Credit Reporting Act

We appreciate your application for insurance and intend to process it as speedily as possible so that you can know whether it has been approved. As is customary in the business world, and as part of our normal underwriting procedure, an investigative consumer report may be obtained. These reports typically include information on a Proposed Insured's character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates. Upon written request to the Underwriting Department at the Company's address above, further information as to the nature and scope of the report will be furnished you.

Notice of Acquisition and Disclosure of Confidential Information
Required by the
Medical Information Bureau (MIB)

Information regarding your insurability will be treated as confidential. Assurity Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

Assurity Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Conditional Receipt

including notices required by the
Fair Credit Reporting Act
and the
Medical Information Bureau (MIB)

The following Conditional Receipt is issued Assurity Life Insurance Company when the full initial premium is collected from the Proposed Insured/Owner at the time the application is completed. The full initial premium may be collected when the amount of in-force and applied for individual life coverage with Assurity Life Insurance Company does not exceed $500,000. This $500,000 limit applies to applications on which the Proposed Insured has fully and accurately answered all health questions indicating no significant health problems. Individual life applications may be accepted without the health questions answered if the Proposed Insured is to be medically examined. However, in these cases, the full initial premium can be collected only when the in-force and applied for coverage does not exceed $100,000 with Assurity Life Insurance Company. The full initial premium may also be collected for individual disability coverage when the amount of in-force and applied for individual disability coverage (base policy Monthly Benefits plus SDIR Monthly Benefit) with Assurity Life Insurance Company does not exceed $2,500 per month. Applications with in-force and applied for amounts that exceed these limits, or where the Proposed Insured has significant health problems, must be handled on a C.O.D. basis.

In addition to the above insurance limits, issuing a Conditional Receipt requires **full modal payment** (including PAC authorization and sample check for PAC mode, if applicable). A Conditional Receipt may **not** be issued in exchange for a postdated check or a partial premium payment. **Payment in this manner in no way conditionally binds Assurity Life Insurance Company.**

Following the Conditional Receipt are two notices required to be given to the Proposed Insured. The federal **Fair Credit Reporting Act** notice explains the nature of investigative consumer reports, and explains the Proposed Insured's rights if such a report is requested. The disclosure regarding the **Medical Information Bureau (MIB)** informs the Proposed Insured of restrictions on obtaining and disclosing confidential medical information.

Conditional Receipt

Assurity Life Insurance Company • Lincoln, Nebraska

The Proposed Insured/Owner's payment of the full initial premium and acceptance of this Conditional Receipt constitutes the Proposed Insured/Owner's acceptance of its terms and conditions. Unless all terms and conditions are fulfilled exactly, no insurance will become effective prior to policy delivery. In all events, any insurance provided is subject to the stated limits. No agent is authorized to change or waive any conditions or limits. Please make **all** premium checks payable to "Assurity Life Insurance Company". Please **do not** make checks payable to the agent or leave "payee" blank.

1. The sum of $_____is received of _____by Assurity Life Insurance Company ("The Company") in payment of the full initial premium on insurance applied for on this date. Payment is accepted subject to the terms and limitations of this Conditional Receipt ("Receipt"). It is expressly understood and agreed that unless all conditions set forth in this Receipt are satisfied, or that unless the coverage applied for is issued within 60 days of the date of application, no insurance shall ever take effect. In such case, the Company's only liability and obligation is to promptly refund the premium payment received.

2. If, on the applicable date, the Proposed Insured was acceptable for the plan and amount of insurance applied for, without modification, under Assurity's rules, limits and standards of insurability, coverage will be effective the later of i) the date of application, or ii) the date any medical examination of the Proposed Insured is completed, if required by the Company. Insurance will be issued at Assurity's standard premium rates applicable to the Proposed Insured's age and occupation on the applicable effective date.

3a. Assurity Life Insurance Company has NO liability for life insurance coverage if the answers to the health questions on the application indicate any significant health problems. Otherwise, the Company's total life insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that for which this Receipt is given) shall not exceed $500,000 if all application health questions are answered, and shall not exceed $100,000 if no application health questions are answered.

b. Assurity Life Insurance Company has NO liability for health insurance coverage and this Receipt is void for any insurance if any health questions on the application have not been answered and no medical examination is required of the Proposed Insured. Otherwise, the Company's total health insurance liability for all coverage previously issued by the Company to the Proposed Insured, plus all coverage applied for to the Company on the Proposed Insured's behalf (including that which this Receipt is given) shall not exceed $2,500 per month.

These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.

4. This Receipt must not be detached and used unless the full amount of the first premium is paid on the date of the application. Payment cannot be accepted with the application if any person proposed for coverage has been treated for or had any known heart trouble, stroke or cancer within the past twelve months. This Receipt is void if exchanged for any check or draft that is not honored upon first presentation for collection through usual banking facilities.

Dated: _____ Agent: _____

Assurity Life Insurance Company
1526 K Street • Box 82533
Lincoln, Nebraska 68501-2533
Telephone Toll-Free: (800) 276-7619, Ext. 4264

COLORADO HIV ANTIBODY TEST INFORMATION FORM

ABOUT AIDS. Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25-50% chance of developing AIDS over the next 10 years.

ABOUT THE TEST. Please read the important information below before you consent to testing:

Purpose: This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

Positive Test Results: If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

Accuracy: An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

a. **False Positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Re-testing should be done to help confirm the validity of a positive test.

b. **False Negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

Side Effects: A positive test result may cause you significant anxiety. A positive test result may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

Disclosure of Results: You will be notified in writing if your application for insurance is denied. Specific results of positive HIV tests will be communicated only to a physician named by you. You should contact your physician for more information about the results of your HIV test.

Confidentiality: Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

Prevention: Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

Information: Further information about HIV testing and AIDS can be obtained by contacting your physician, your county health department, or your State Health Department.

Assurity Life Insurance Company
1526 K Street • Box 82533
Lincoln, Nebraska 68501-2533
Telephone Toll-Free: (800) 276-7619, Ext. 4264

COLORADO INFORMED CONSENT TO HIV ANTIBODY TEST

I authorize Assurity Life Insurance Company (the "Company") and its designated medical facilities to draw samples of my blood or other bodily fluid for the purpose of laboratory testing to provide applicable medical information about my insurability. These tests may include but are not limited to tests for cholesterol and related blood lipids, diabetes, hepatitis, liver or kidney disorders, infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law), immune disorders or the presence of medications, drugs, nicotine or other metabolites. The tests will be done by an extremely reliable medically accepted procedure.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA blood or other bodily fluid test will be done.
   a. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.
   If the initial ELISA blood or other bodily fluid test is negative, a negative finding will be reported to the Company.
2. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.
   a. If the second ELISA blood or other bodily fluid test is also positive, a Western Blot blood or other bodily fluid test will be performed to confirm the positive results of the two ELISA blood or other bodily fluid tests.
   b. If the second ELISA blood or bodily fluid test is negative, a third ELISA blood or bodily fluid test will be performed. If that ELISA blood or bodily fluid test is positive, a Western Blot blood or bodily fluid test will be performed to confirm the previous positive results. If the third ELISA blood or bodily fluid test is negative, a negative test result will be reported to the Company.
3. Only if at least two ELISA blood or bodily fluid tests and a Western Blot blood or bodily fluid test are all positive will the result be reported as positive. All other results will be reported as negative to the Company.

Without a court order or written authorization from me, these results will be made known only to the Company and/or it reinsurers involved in the underwriting process. In addition, the Company may make a brief report to MIB in a manner described in the information I received as part of the application process. The Company will only report to MIB that positive results were obtained from a blood or other bodily fluid test. The Company will not report what tests were performed or that the positive result was for HIV antibodies. These organizations will be the only ones maintaining this information in any type of file except as required by law.

The Company will provide results of all tests to a physician of my choice. Positive test results to the HIV Antibody Test will be disclosed only to my physician at the following address:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

This authorization will be valid for 90 days from the date below. 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.

Dated at: _____ on _____

City and State Month, Date and Year

_____ _____

Signature of Proposed Insured (or Parent/Guardian) Signature of Witness (Agent's Signature)

ASSURITY LIFE INSURANCE COMPANY
1526 K Street - PO Box 82533
Lincoln, NE 68501-2533
Toll Free 800-276-7619, Ext. 4264

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Assurity Life Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ Other (please specify)

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you 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 and 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 has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Signed form to be returned to Home Office.
Applicant to receive a copy of signed form at time the application is taken

ASSURITY LIFE INSURANCE COMPANY
1526 K Street - PO Box 82533
Lincoln, NE 68501-2533
Toll Free 800-276-7619, Ext. 4264

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Producer or Other Representative)*
{Typed Name and Address of Insurance Producer}

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

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{Typed Name and Address of Insurance Producer}

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(Applicant's Signature)

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Phone: 800-276-7619, Ext. 4264 • Fax 402-437-4558

Automatic Bank Withdrawal

Automatic Bank Withdrawal conveniently pays your premium from your checking account – saving you time and money. To begin this convenient service, please complete the form below and return it to us. Remember to indicate the date of withdrawal that would be most convenient for you.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account.

DRAFT INITIAL PREMIUM PAYMENT: ☐ **Yes** ☐ **No**
If Yes is marked, the first premium for this insurance will be debited from your account at the time the policy is issued.

Name of Financial Institution	Routing Number (9 digit number beginning with 0, 1, 2, or 3)	Account Number

Date of Withdrawal: _____ (cannot be the 29th, 30th or 31st)
IF NO DATE IS ENTERED, THE POLICY ISSUE DATE WILL BE USED

Type of account: ☐ Checking ☐ Savings

Signature of Account Holder	Date Signed	Telephone Number

Policy Number(s) (if applicable): _____ _____ _____ _____

ATTACH VOIDED CHECK HERE

Assurity Life Insurance Company
1526 K Street • Box 82533
Lincoln, Nebraska 68501-2533
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COLORADO HIV ANTIBODY TEST INFORMATION FORM

ABOUT AIDS. Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25-50% chance of developing AIDS over the next 10 years.

ABOUT THE TEST. Please read the important information below before you consent to testing:

Purpose: This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

Positive Test Results: If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

Accuracy: An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

a. **False Positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Re-testing should be done to help confirm the validity of a positive test.

b. **False Negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.

Side Effects: A positive test result may cause you significant anxiety. A positive test result may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

Disclosure of Results: You will be notified in writing if your application for insurance is denied. Specific results of positive HIV tests will be communicated only to a physician named by you. You should contact your physician for more information about the results of your HIV test.

Confidentiality: Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

Prevention: Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

Information: Further information about HIV testing and AIDS can be obtained by contacting your physician, your county health department, or your State Health Department.

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The Company will provide results of all tests to a physician of my choice. Positive test results to the HIV Antibody Test will be disclosed only to my physician at the following address:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

This authorization will be valid for 90 days from the date below. 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.

Dated at: _____ on _____

City and State Month, Date and Year

_____ _____

Signature of Proposed Insured (or Parent/Guardian) Signature of Witness (Agent's Signature)

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