PLEASE PRINT WITH BLACK INK

APPLICATION FOR INSURANCE

ASSURITY LIFE INSURANCE COMPANY 1526 K Street, PO Box 82533, Lincoln NE 68501-0926	☐ New application ☐ Takeover ☐ Addition, increase or change to existing coverage; existing Policy No. _____

Primary Proposed Insured - Employee

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

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

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

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

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

For ALL COVERAGES, please answer the following questions.

1. During the past **90 days**, have you worked less than 30 hours per week in your primary occupation? ☐ Yes ☐ No

2. During the past **90 days**, have you been unable to perform any of the duties of your primary occupation? ☐ Yes ☐ No

3. Has any Proposed Insured ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency (AIDS), AIDS Related Complex (ARC) or Antibodies to Human T-lymphotrophic Virus Type III (HTLV); or had a positive test for HIV (Human Immunodeficiency Virus) antibodies? ☐ Yes ☐ No
   If YES, identify name(s) of person(s) _____

4. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
   If YES, complete replacement form provided by your agent if required by your state.

5. Is there any other life, cancer, heart/stroke, disability, hospital indemnity, critical illness or accident insurance in force or applied for on any Proposed Insureds? ☐ Yes ☐ No
   If YES, list person, company name, policy number, year issued, type of coverage and amount of benefit.
   _____
   _____
   _____

Primary Proposed Insured Name _____

ACCIDENT EXPENSE

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

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

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

Primary Proposed Insured Name _____

SHORT-TERM DISABILITY INCOME

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

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

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

Please answer the following questions.

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

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

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

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

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

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

Primary Proposed Insured Name _____

CRITICAL ILLNESS

Plan	Insured Options	Benefit Options	Riders	Premium Amt
☐ Critical Illness	☐ Employee ☐ Spouse ☐ Child	Employee Benefit Amt. $_____ Spouse Benefit Amt. $_____	☐ Cancer Benefit Rider ☐ Wellness Benefit Rider ☐ Other (specify) _____	

Please answer the following questions.

1. During the past 12 months, has any Proposed Insured used any form of tobacco or nicotine-based products, or substitutes such as patches or gum?.....Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

2. During the past 12 months, has any Proposed Insured been hospitalized, disabled or advised to have diagnostic tests (except for HIV tests) or any medical or surgical procedures by a medical professional that have not been completed or for which results have not been received? (If YES, please provide details in #9 below.)..... ☐ Yes ☐ No

3. During the past 10 years, has any Proposed Insured had or been advised to have an organ or tissue transplant, or consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following: disease or disorder of the heart (including heart attack, heart condition, congestive heart failure, heart valve disorder), circulatory system (including peripheral vascular disease, carotid artery disease), liver, lungs (excluding asthma but including emphysema, Chronic Obstructive Lung and Pulmonary Disease), kidneys or pancreas; hepatitis (other than type A); stroke; Transient Ischemic Attack (TIA); insulin dependent diabetes; dementia; Alzheimer's Disease; paralysis; multiple sclerosis; muscular dystrophy; alcohol or drug abuse? (If YES, please provide details in #9 below.)..... ☐ Yes ☐ No

4. During the past 6 months, has any Proposed Insured had any blood pressure readings of 160/100 or higher? (If YES, please provide details in #9 below.)..... ☐ Yes ☐ No

5. During the past 10 years, has any Proposed Insured needed assistance or personal supervision to perform any activities of daily living (toileting, transferring, continence, eating, bathing, or dressing)? (If YES, please provide details in #9 below.)..... ☐ Yes ☐ No

6. If applying for a Benefit Amount above $30,000: Have any two or more of the Proposed Insured's natural parents or siblings, either living or deceased, ever consulted with or been diagnosed, treated or prescribed medication by a medical professional before the age of 60 for the same condition from the following list: disease or disorder of the heart (including heart attack, heart condition, heart valve disorder), kidney disease, stroke, diabetes, cancer or Alzheimer's Disease? (If YES, please provide details in #9 below.)..... ☐ Yes ☐ No

7. If applying for the Cancer Rider: During the past 10 years, has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for internal cancer, leukemia, lymphoma, Hodgkin's Disease, melanoma, malignant tumors or carcinoma in situ? (If YES, please provide details in #9 below.)..... ☐ Yes ☐ No

8. If applying for the Cancer Rider: During the past 12 months, has any Proposed Insured been hospitalized, disabled or advised to have diagnostic tests or any medical or surgical procedures by a medical professional that have not been completed or for which results have not been received? (If YES, please provide details in #9 below.) ..... ☐ Yes ☐ No

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

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

Primary Proposed Insured Name _____

CANCER EXPENSE

Plan	Insured Options	Benefit Options	Riders	Premium Amt
☐ Cancer Expense	☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Family	Radiation/Chemotherapy ☐ $5,000/$25,000 ☐ $5,000/$50,000 ☐ $10,000/$50,000 ☐ $10,000/$100,000 Hospital Confinement ☐ $150 ☐ $250 ☐ $350	☐ Cancer First Occurrence Benefit Rider ☐ $2,500 ☐ $5,000 ☐ Intensive Care Unit Benefit Rider ☐ $300 ☐ $600 ☐ Specified Disease Benefit Rider ☐ Other _____	

Please answer the following questions.

1. During the past 10 years, has any Proposed Insured been advised by a medical professional to have any diagnostic tests related to cancer that have not been completed or for which results have not been received? ☐ Yes ☐ No
   (If YES, please provide details in #7 below.)

*2. During the past 10 years, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, internal cancer, leukemia, Hodgkin's lymphoma (formerly known as Hodgkin's disease), melanoma, malignant tumors or carcinoma in situ? ☐ Yes ☐ No
   If YES, identify name(s) of person(s) _____

*3. During the past 5 years, has any Proposed Insured been treated for or diagnosed with non-melanoma skin cancer? ☐ Yes ☐ No
   If YES, identify name(s) of person(s) _____

*4. **If applying for the Specified Disease Benefit Rider:** During the past 10 years, has any Proposed Insured consulted with or been diagnosed, treated or hospitalized by a medical professional for, or had symptoms of, any of the following diseases: Addison's disease, botulism, brucellosis, Budd-Chiari syndrome, cystic fibrosis, diphtheria, encephalitis, histoplasmosis, Legionnaires' disease, Lou Gehrig's disease, systemic lupus erythematosus, malaria, meningitis, multiple sclerosis, muscular dystrophy, myasthenia gravis, osteomyelitis, polio, Q fever, Reye's syndrome, rheumatic fever, Rocky Mountain spotted fever, sickle cell anemia, Tay-Sachs disease, tetanus, toxic shock syndrome, trichinosis, tuberculosis, typhoid fever or whooping cough? ☐ Yes ☐ No
   If YES, identify name(s) of person(s) _____

*5. **If applying for the Intensive Care Unit Benefit Rider:** During the past 10 years, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of: disease or disorder of the heart (including heart attack, heart condition, heart valve disorder), high blood pressure with reading of 160/100 or higher, stroke or insulin-dependent diabetes? ☐ Yes ☐ No
   If YES, identify name(s) of person(s) _____

*For person(s) listed, the Elimination and Amendment of Benefits form must be completed and signed by the Primary Proposed Insured.

6. **If applying for the Intensive Care Unit Benefit Rider:** Are you or any family member applying for coverage currently pregnant? ☐ Yes ☐ No
   If YES, identify name(s) of person(s) _____

7. DETAILS: Enter any details from question #1 below. (If additional space is needed, attach a separate sheet of paper.)

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

Primary Proposed Insured's Name _____

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

By signing this application, the applicant attests that all Proposed Insured(s) *(except those listed below)* have other health coverage that satisfies the requirement for minimum essential coverage. Indicate which Proposed Insureds do not have such coverage below. A hospital indemnity policy cannot be issued to those listed.

HOSPITAL INDEMNITY

Plan	Insured Options
☐ Hospital Indemnity	☐ Employee ☐ Employee/Spouse ☐ Family ☐ Employee/Child

Benefit Options

Daily Benefit Amount $ _____

Benefit Period ☐ 180 days ☐ 365 days

Sickness Elimination ☐ 0 days ☐ 7 days

Premium Amount *(indicate amount and frequency)*

$ _____ _____

Riders

- ☐ AD&D Benefit Rider
  - Employee $_____
  - Spouse $_____
- ☐ Critical Illness Benefit Rider
  - ☐ $5,000 ☐ $10,000
- ☐ Diagnostic Benefit Rider
- ☐ Emergency Accident Benefit Rider
  - ☐ $100 ☐ $150 ☐ $200
- ☐ First Hospital Admission Benefit Rider
- ☐ Intensive Care Unit Benefit Rider $ _____
- ☐ Outpatient Sickness Benefit Rider
  - ☐ $25 ☐ $50 ☐ $75 ☐ $100
- ☐ Private Duty Nurse Benefit Rider
- ☐ Surgical/Anesthesia Benefit Rider $ _____
- ☐ Wellness Benefit Rider
- ☐ Other (specify) _____

Please answer the following questions.

1. Currently or during the past **12 months**, has any Proposed Insured:
   - a. Been hospitalized two or more times? ☐ Yes ☐ No
   - b. Been hospitalized for five or more days? ☐ Yes ☐ No
   - c. Been advised by a medical professional to be hospitalized? ☐ Yes ☐ No
   - d. Been advised by a medical professional to have any medical or surgical procedures or diagnostic tests performed that have not been completed or for which results have not been received? ☐ Yes ☐ No
   - e. Been undergoing evaluation following abnormal test results? ☐ Yes ☐ No

   If YES to any of the above, please indicate which Proposed Insured(s) _____

2. During the past **12 months**, has any Proposed Insured been hospitalized or received emergency treatment for any of the following:
   - a. Asthma, chronic obstructive pulmonary disease *(COPD)* or emphysema? ☐ Yes ☐ No
   - b. Liver disease or disorder *(excluding hepatitis A)*? ☐ Yes ☐ No
   - c. Parkinson's disease? ☐ Yes ☐ No
   - d. Anemia? ☐ Yes ☐ No
   - e. Drug or alcohol abuse? ☐ Yes ☐ No

   If YES to any of the above, please indicate which Proposed Insured(s) _____

3. During the past **3 years**, has any Proposed Insured been hospitalized or received emergency treatment for any of the following:
   - a. Angina *(heart-related chest pain)*, heart attack, heart surgery, arrhythmia with pacemaker or congestive heart failure? ☐ Yes ☐ No
   - b. Cerebral vascular insufficiency, peripheral vascular disease, stroke or transient ischemic attack *(TIA/mini-stroke)*? ☐ Yes ☐ No
   - c. Crohn's disease or ulcerative colitis? ☐ Yes ☐ No
   - d. Multiple sclerosis? ☐ Yes ☐ No

   If YES to any of the above, please indicate which Proposed Insured(s) _____

4. During the past **5 years**, has any Proposed Insured been diagnosed with or treated for internal cancer or any malignancy, including but not limited to, carcinoma, sarcoma, malignant melanoma, Hodgkin's disease, leukemia, lymphoma or malignant tumor? *(For this question only, cancer does not include basal cell or squamous cell carcinoma.)* ☐ Yes ☐ No

   If YES, please indicate which Proposed Insured(s) _____

5. Has any Proposed Insured **ever** been diagnosed with or received treatment by a medical professional for:

a. Kidney disease *(excluding kidney stones or urinary tract disorders)*? ☐ Yes ☐ No

b. Uncorrected congenital heart defect *(excluding mitral valve prolapse)*? ☐ Yes ☐ No

c. Cystic fibrosis or muscular dystrophy? ☐ Yes ☐ No

d. Systemic lupus or any other autoimmune disease? ☐ Yes ☐ No

e. Insulin-dependent diabetes diagnosed prior to age 30 or diabetes with complications, including but not limited to, retinopathy, neuropathy or nephropathy? ☐ Yes ☐ No

f. Senile dementia or Alzheimer's disease? ☐ Yes ☐ No

g. An organ transplant or the potential need for an organ transplant? ☐ Yes ☐ No

If YES to any of the above, please indicate which Proposed Insured(s) _____

If any items in question 1-5 are answered YES, the indicated Proposed Insured will not be covered under this policy or any rider.

Question 6 MUST be answered in all cases if applying for the Critical Illness Rider.

6. **If applying for the Critical Illness Rider:** During the past **10 years**, has any Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, any of the following: disease or disorder of the heart *(including heart attack, heart condition, heart valve disorder, congestive heart failure)* or circulatory system; stroke; transient ischemic attack *(TIA)*; peripheral vascular disease; carotid artery disease; insulin dependent diabetes; internal cancer; leukemia; lymphoma; Hodgkin's disease; melanoma; malignant tumors or carcinoma in situ? ☐ Yes ☐ No

If YES to any of the above, please indicate which Proposed Insured(s) _____

Primary Proposed Insured Name _____

Primary Proposed Insured's Agreement

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

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

HOME OFFICE CORRECTIONS AND ADDITIONS ONLY

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

Issue Date _____

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

Primary Proposed Insured's Signature _____

Payor's Signature (for Term Life only) _____

Agent's Statement and Agreement

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

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

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

Group No. _____

Primary Proposed Insured Name _____

ELIMINATION AND AMENDMENT OF BENEFITS

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

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

Elimination of Benefits

a. Skin Cancer

Assurity Life Insurance Company will not be liable for any loss resulting from skin cancer affecting

_____
Name(s)

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

b. Specified Diseases Rider

Assurity Life Insurance Company will not be liable for any loss resulting from

_____
Specified Disease(s)

affecting _____ ,
Name(s)

which is excluded from coverage for the named Specified Disease(s).

c. Intensive Care Unit Rider

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

_____
Name(s)

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

Amendment of Benefits

d. All Cancers including malignant melanomas and carcinoma in situ

Assurity Life Insurance Company is amending coverage to show

_____
Name(s)

is excluded from coverage under this policy and any attached riders.

Amendment of Benefits for All Other Plans

e. Removal of an Individual

Assurity Life Insurance Company is amending coverage to show

_____
Name(s)

is excluded from coverage under this policy and any attached riders

f. Removal of a Benefit Rider

Assurity Life Insurance Company is amending coverage to show that no benefits are available under

_____
Rider Name and Form Number

for _____
Name(s)

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