ASSURITY® LIFE INSURANCE COMPANY
Toll-free Number: (800) 276-7619, Extension 4264
AssureLINK Address: http://assurelink.assurity.com

Critical Illness

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

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

✓ The application should coincide with the **state in which the policy owner resides** for the following states:

- AR, GA, ID, IL, ME, MT, NH, NC, ND, OK, PA, SD, TX, UT and WV

All other applications should coincide with **the state in which the application is to be signed**.

✓ 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.**

✓ Use **age last birthday** when preparing illustrations and/or calculating insurance premiums.

✓ 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.

✓ 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 **underwriting-related questions** *(including "what if" scenarios)*, **call toll-free** (800) 276-7619, EXT. 4264 **or email** to underwriting@assurity.com.

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

Application for INSURANCE

PLEASE PRINT IN BLUE OR BLACK INK

1. PROPOSED INSURED

First / Middle / Last	(MM/DD/YYYY)
Legal Name	Date of Birth / /

Social Security No.	☐ Male ☐ Female	E-mail	Age

Street Address / City / State / ZIP+4
Home Address

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? ..... ☐ Yes ☐ 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 *(green card)* status? ..... ☐ Yes ☐ No

If the Proposed Insured has permanent resident status, please list permanent resident *(green card)* number.

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number.

Years Months

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No Length of employment /

Primary Employer	Employer's Address (Street Address / City / State / ZIP+4)

Full-time Employment (Occupation / Duties)	Part-time Employment (Occupation / Duties)
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.

First / Middle / Last	(MM/DD/YYYY)
Legal Name	Date of Birth / /

Social Security No.	Relationship to Insured	Birth State/Country
Home Address (Street Address / City / State / ZIP+4)		E-mail

Contingent Owner's Name (First / Middle / Last)	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 *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Soc. Sec. No.**	**Date of Birth**	**Share %**
			/ /	
			/ /	

4. PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below:

Type

☐ Direct Billing ☐ ~~Automatic Credit Card~~
☐ List Billing *(employer)* ☐ Automatic Bank Withdrawal

Frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ Monthly *(not available with Direct Billing)*

Payor Name (First / Middle / Last)	Billing Address (Street Address / City / State / ZIP+4)
Secondary Payor Info. (First / Middle / Last)	Billing Address (Street Address / City / State / ZIP+4)

TRUST INFORMATION/ADDITIONAL BENEFICIARY

Please complete the following sections if Ownership and/or Beneficiary is a trust *(or if additional room is needed to list beneficiaries of Policy)*:

1. POLICYOWNER

Name of Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Address of Trustee(s) *Street Address* *City* *State* *ZIP+4*

2. BENEFICIARIES

☐ Testamentary Trust *(Will)* Share % _____

☐ Living Trust *(Please complete information below.)* Share % _____

Name of Living Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Street Address *City* *State* *ZIP+4*

Address of Trustee(s)

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

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
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			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Social Security No.**	**Date of Birth *(MM/DD/YYYY)***	**Share %**
			/ /	
			/ /	
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			/ /	

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 coverage, please complete and return the appropriate State Replacement Form.

Insured's Name	Company Name	Policy No.	Individual (I) Group (G)	Benefits *(monthly benefit and benefit period for DI or face amount for Life)*	Issue Date *(MM/DD/YYYY)*	DI Coverage Only: Coordinates w/ Soc. Sec.?	DI Coverage Only: Employer Paid?
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ 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. Has any Proposed Insured **ever** 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. Has any Proposed Insured **ever** 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. Has any Proposed Insured **ever** 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 *(First, Middle, Last)*	Onset Date *(MM/DD/YYYY)*	Duration *(Days, Mos, Yrs)*	Health Condition and Details	Medical Care Provider's Name/Address/Phone
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Additional Information:

Home Office Use Only

CRITICAL ILLNESS PRODUCT SECTION

Benefit Amount $ _____

ADDITIONAL BENEFITS *(If available)*

Check benefit(s) desired and indicate amount requested.

☐ Accidental Death Benefit Rider $ _____

☐ Disability Waiver of Premium Rider

☐ Spouse Critical Illness Benefit Rider $ _____
(complete information below)

☐ Dependent Child Critical Illness Benefit Rider ☐ $5,000 ☐ $10,000
(complete information below)

SPOUSE AND CHILD RIDER INFORMATION—If additional space is needed, attach a separate sheet of paper.

Information	Spouse	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name *(First, Middle, Last)*				
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed Insured	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Employer				
Occupation/Duties				
Gross monthly income	$			
If self-employed, net monthly income	$			

Has the Proposed Insured's Spouse ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? . ☐ Yes ☐ No

If YES, please list type: amount per day: last date of use *(MM/DD/YYYY)* / /

Is the Proposed Insured's Spouse a United States citizen, or does he/she have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If the Proposed Insured's Spouse has permanent resident status, please list permanent resident *(green card)* number.

Does the Proposed Insured's Spouse have a valid driver's license? ..... ☐ Yes ☐ No

If YES, please list state of issue and number.

CRITICAL ILLNESS HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details in #7 below.

1. Has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following:
   a. Heart attack, stroke, elevated or abnormal cholesterol, angina, coronary heart disease, disease of the blood vessels or TIA *(transient ischemic attack)*? ☐ Yes ☐ No
   b. Thyroid disorder, hepatitis, hepatitis carrier, anemia, fatigue, disorder of the pancreas, any lupus or any other blood or glandular disorder? ☐ Yes ☐ No
   c. Polyp, mole, lump, other growth, breast disorder or abnormal mammogram, biopsy or abnormal prostate specific antigen *(PSA)* test? ☐ Yes ☐ No
2. Does any Proposed Insured regularly take any prescription medications? If YES, specify type and daily dosage in #7 below. ☐ Yes ☐ No
3. During the past **5 years**, has any Proposed Insured consulted any physician for any reason not detailed above? ☐ Yes ☐ No
4. Is any Proposed Insured aware of any symptoms or complaints regarding their health for which they have not yet consulted a physician? ☐ Yes ☐ No
5. Has any Proposed Insured been advised to have surgery, treatment or testing which has not been completed? ☐ Yes ☐ No
6. Has any Proposed Insured ever used marijuana or any illegal or addictive drugs? ☐ Yes ☐ No
7. **DETAILS:** Enter complete details from questions #1-6 below. If additional space is needed, attach a separate sheet of paper.

Question #/Letter	Name *(First, Middle)*	Onset Date *(MM/DD/YYYY)*	Duration *(Days, Mos, Yrs)*	Health Condition and Details Including Prescription Medication(s)	Medical Care Provider's Name/Address/Phone
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			

8. Has any immediate family member *(whether living or deceased)* of any Proposed Insured ever suffered from, or is currently suffering from: cancer, heart disease, stroke, kidney disease, diabetes, ALS *(amyotrophic lateral sclerosis or Lou Gehrig's disease)*, motor neuron disease, Alzheimer's disease, Huntington's disease, Parkinson's disease or any other hereditary disease? If YES, please provide details below. If additional space is needed, attach a separate sheet of paper. ☐ Yes ☐ No

Proposed Insured's Name	Family Member/ Relationship	Diagnosis	Age at Time of Diagnosis

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 _____

Results _____

_____

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 shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

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 _____ on ____/____/____
City *State* *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 REQURE 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*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • www.assurity.com

Confidential Information Authorization

_____ / / _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

_____ / / _____
Legal Name of Additional Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name	***Date of Birth***	*Legal Name*	***Date of Birth***

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau),* or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- 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 diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions *(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.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

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, MIB Inc., 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 redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be rediscloseed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(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)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • www.assurity.com

Confidential Information Authorization

_____ / / _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

_____ / / _____
Legal Name of Additional Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name	***Date of Birth***	*Legal Name*	***Date of Birth***

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau),* or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- 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 diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions *(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.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

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, MIB Inc., 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 redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be rediscloseed in accordance with other applicable laws or regulations.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(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)*

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Confidential Information Authorization for Release of Psychotherapy Notes

_____ / / _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

_____ / / _____
Legal Name of Additional Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name	***Date of Birth***	*Legal Name*	***Date of Birth***

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau),* or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- Psychotherapy notes

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

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, MIB Inc., 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 redisclosure 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.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twelve *(12)* months from the date of 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)*

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

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Confidential Information Authorization for Release of Psychotherapy Notes

_____ / / _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

_____ / / _____
Legal Name of Additional Applicant/Insured/Claimant (Please print) ***Date of Birth*** *(MM/DD/YYYY)*

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name	***Date of Birth***	*Legal Name*	***Date of Birth***

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau),* or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- Psychotherapy notes

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

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, MIB Inc., 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 redisclosure 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.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twelve *(12)* months from the date of 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.

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ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (888) 255-2060

CONSUMER NOTICE

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.

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.

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Temporary Conditional Insurance Agreement

(for use with all Health products)

Please make premium check(s) payable to Assurity Life Insurance Company. Do not make checks payable to the agent. Do not leave the check payee blank.

This Temporary Conditional Insurance Agreement is void if altered or modified. No agent is authorized to change or waive any terms, conditions or limitations stated herein.

Proposed Insured No. 1 _____ Date Application Signed ___/___/___

Proposed Insured No. 2 _____ Date Application Signed ___/___/___

TERMS AND CONDITIONS

In consideration of $_____ in premium received by Assurity Life Insurance Company *(Assurity)* and subject to the limitations stated herein, insurance will become effective under this Temporary Conditional Insurance Agreement *(Agreement)* if all of the terms and conditions stated below are fulfilled exactly. The effective date *(Effective Date)* of coverage under this Agreement will be the later of: i) the date of application; or ii) the date any medical examination of the Proposed Insured(s) is completed, if required by Assurity.

Subject to the limitations below, insurance will become effective under this Agreement on the Effective Date if the following conditions are fulfilled exactly:

1. The first full premium has been paid and the check is honored on first presentation for payment;
2. The application and any required medical examination(s) are completed in full;
3. On the Effective Date, all statements given in the application are true and complete;
4. On the Effective Date, the Proposed Insured(s) is insurable at Assurity's **standard or better than average rates** *(no ratings included)*, according to Assurity's underwriting practices for the amount of insurance and any additional benefits applied for; and
5. The Policy is issued by Assurity exactly as applied for within 90 days from the date of application, delivered and accepted by the Proposed Insured(s).

Except as stated herein, coverage under this Agreement is subject to the same terms, including any limitations and exclusions, which would be part of the Policy if issued as applied for.

MAXIMUM AMOUNT LIMITATION

Assurity's liability under this Agreement is limited to:

- $2,500 of disability coverage or business overhead coverage;
- The amount of hospital indemnity coverage applied for; or
- $50,000 of critical illness coverage, including any other critical illness coverage applied for with Assurity.

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

REFUND OF PAYMENT

There will be no insurance coverage under this Agreement, and Assurity's liability will be limited to a return of the premium submitted if:

- The Policy applied for is not issued within 90 days of the date of application;
- Any of the terms or conditions set forth in this Agreement are not satisfied; or
- The application contains a material misrepresentation to Assurity.

Dated at _____ On _____
City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

ASSURITY® LIFE INSURANCE COMPANY
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Temporary Conditional Insurance Agreement

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- Any of the terms or conditions set forth in this Agreement are not satisfied; or
- The application contains a material misrepresentation to Assurity.

Dated at _____ On _____
City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

WHAT YOU NEED TO KNOW ABOUT HIV TESTING

In connection with your insurance, your blood sample will be tested for the presence of the AIDS virus *(HIV)* antibody. Before consenting to this test, please read this information:

Q: What is HIV and how is it spread?

A: HIV, or human immunodeficiency virus, infection is a long-term illness that damages the body's immune system, or its ability to fight off diseases. HIV spreads through blood, semen, vaginal fluids and breast milk. You can get or give HIV infection by:

- Having vaginal, anal or oral sex without a condom.
- Sharing needles or works when injecting drugs.
- HIV can be passed from mother to child during pregnancy, birth or breastfeeding.
- You **cannot** get HIV by donating blood or through casual contact such as hugging or shaking hands.

Q: What is AIDS?

A: AIDS, or acquired immunodeficiency syndrome, is the stage of HIV infection when the body is weakened and less able to fight off germs.

Q: What is an HIV test?

A: It is a simple test, done by taking blood or fluid from cells in the mouth that shows if you've been infected with HIV, the virus that causes AIDS.

Q: Who should have an HIV test?

A: The CDC *(Centers for Disease Control and Prevention)* recommends that everyone between the ages of 13 and 64 get tested for HIV.

Whatever your age, you should have an HIV test if you are sexually active or have shared needles or works for injecting drugs.

Women who are pregnant or considering pregnancy should also get an HIV test.

Q: Can anyone make me take an HIV test?

A: Under Michigan law, unless you are ordered by a judge, or you are a prisoner entering into a state correctional facility, getting an HIV test is your decision. No one can test you without getting your consent.

Q: Can I change my mind after I consent to the test?

A: Yes, you can change your mind at any time before the lab runs the test.

If you change your mind, you must give your health care provider a written request saying that you do not want your test to be run.

Q: Can someone under age 18 take the test without parental consent?

A: Yes, minors age 13 and older have the right to take the test for HIV without their parents' knowledge or consent.

Q: What's the difference between anonymous and confidential testing?

A: Anonymous HIV testing means your name is not used and will not be on the test results. To get your results, you will be given a code number.

Confidential HIV testing means that your name will be used on your test results.

If you get an anonymous HIV test, you will not receive a piece of paper with your name and your test results. If you need a copy of your HIV test results, you should take a confidential test.

In Michigan, you have the right to request an anonymous HIV test.

Q: How is HIV testing done?

A: Typical HIV tests are done on blood or oral fluids. Specimens are sent to a lab and you get your results in about one week. When testing blood, a needle will be used to draw blood from a vein in your arm. When testing oral fluids, they are collected on a swab from your mouth.

Rapid test: Some clinics or testing sites offer rapid testing. This is a test done on a small amount of blood from the tip of your finger or from fluid in your mouth. You will get results in that same visit. If your result is reactive *(shows possible signs of infection)*, you will need more testing.

Q: How will this test help me?

A: The test will tell you whether or not you have HIV. People can have HIV for years and not know it unless they are tested.

If you **are infected**, it can help you get proper treatment and learn how to avoid spreading HIV to other people.

If you **are not infected**, it can help you learn how to reduce your risk of getting HIV.

Q: What does a negative *(or "non-reactive")* result mean?

A: A **negative result** means you are not infected with HIV, **OR** you have been infected too recently for it to show up on the test.

If you recently had sex without a condom or shared needles, you should get another test in about six weeks. This is because sometimes HIV tests cannot detect recent infection.

Q: What does a positive result mean?

A: A **positive result** means that you are living with HIV.

You should see a doctor as soon as possible. The person who gave you your test results can help you find a doctor if you do not have one.

If you have HIV, you can pass your infection to other people through sex, sharing needles, or through birth or breastfeeding if you are or will be a mother.

You should use condoms every time you have sex, to prevent passing the infection to others. The person who gave you your test results can help plan ways to keep from passing your infection on to others.

Q: Who will know the results of my test?

A: In Michigan, all HIV test information is confidential, by law.

This means that there are very strict rules about who is allowed to see that information.

Health care workers that are involved in your care may see your test results.

Health insurance companies, Medicare and Medicaid, if they are paying all or part of the cost of your health care, will also see your test results.

All positive HIV tests are reported to the health department.

If you have HIV, Michigan law requires that your doctor or someone from the local health department notify all of your known sexual and/or needle-sharing partners that they may have been exposed to HIV. They do this without using your name, or sharing any information about you.

It is illegal to discriminate against people with HIV.

Q: If I have HIV, will I definitely develop AIDS or get sick?

A: No. Today there are many treatments for HIV. These treatments can prevent serious illness, including AIDS. If you get care quickly, you have a chance for a long and healthy life.

Q: Whom should I tell if I have HIV?

A: Current, past and future sexual and/or needle-sharing partners should be notified.

Your local health department can also help to notify partners. They will do this without using your name or sharing any information about you. Your doctor, health care provider or counselor that performed the test can connect you with the local health department.

Michigan law requires you to tell any current or future sexual partner that you have HIV before having any kind of sex with them. The law also requires that your doctor or someone from the local health department talk to you about this.

Q: What if I have more questions?

A: Feel free to ask the health professional who gave you this information any questions you that you might have.

Call the Michigan statewide HIV/AIDS information hotline *(English 1-800-872-AIDS; Spanish 1-800-862-SIDA; TDD 1-800-332-0849)*.

Visit the CDC's HIV/AIDS website for more information *(http://www.cdc.gov/hiv/)*.

ASSURITY® LIFE INSURANCE COMPANY
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Consent and Authorization Form

CONSENT FORM FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

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

I have been informed that my blood, an oral sample from my mouth, or my urine will be tested for antibodies to the human immunodeficiency virus *(HIV)*, the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to:

_____ and as permitted under state law.
Physician's name and/or health facility who will receive the HIV test results

I understand that I have the right to have this test done without the use of my name. If my private physician does not provide anonymous testing, I understand I may obtain anonymous testing at any Michigan Community Public Health Agency-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the information contained in "*What You Need to Know About HIV Testing*." I have been given the opportunity to ask questions concerning the test for HIV antibodies, and I acknowledge that my questions have been answered to my satisfaction.

By my signature below, **I consent to be tested** for HIV.

_____ / _____ /		
Date (MM/DD/YYYY)	*Signature of Proposed Insured or Parent/Guardian*	*Printed Name of Proposed Insured*
_____ / _____ /		
Date (MM/DD/YYYY)	*Signature of Witness*	*Printed Name of Witness*

At this time, **I do not wish to be tested** for the human immunodeficiency virus.

_____ / _____ /		
Date (MM/DD/YYYY)	*Signature of Proposed Insured or Parent/Guardian*	*Printed Name of Proposed Insured*
_____ / _____ /		
Date (MM/DD/YYYY)	*Signature of Witness*	*Printed Name of Witness*

AUTHORIZATION FOR THE RELEASE OF THE RESULT OF THE HUMAN IMMUNODEFICIENCY VIRUS TEST

EXPLANATION: This is an authorization for release of the result of an HIV test. By signing this form, you will indicate to whom the test results may be given.

AUTHORIZATION: I hereby permit _____
Name of physician, hospital, or other provider

to furnish to _____ _____ the result of the HIV test.
Name or title of person to receive result *Name or title of any additional person to receive result*

USES: The requestor may not use the information for any purpose, except the following: _____

_____

DURATION: This authorization may be withdrawn if requested in writing before the information is released.

This authorization shall become effective immediately and shall remain in effect indefinitely or until _____
Date (MM/DD/YYYY)

RESTRICTIONS: I understand that the requestor may not further use or release this medical information, unless another authorization is obtained from me or unless such use or release is specifically required or permitted by law.

ADDITIONAL COPY: I further understand that I have the right to receive a copy of this consent and authorization upon my request.

Copy requested and received? ☐ YES ☐ NO _____ INITIAL

_____ / _____ /		
Date (MM/DD/YYYY)	*Signature of Proposed Insured or Parent/Guardian*	*Printed Name of Proposed Insured*
_____ / _____ /		
Date (MM/DD/YYYY)	*Signature of Witness*	*Printed Name of Witness*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

Automatic PREMIUM PAYMENT

PLEASE PRINT WITH BLACK INK

Name of Proposed Insured _____
First *Middle* *Last*

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

The company's authority to debit from your account the first premium for this insurance does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Day of Withdrawal _____ Day ***cannot*** be the 29th, 30th or 31st. If no day is entered, the policy issue date will be used. Assurity will begin processing your bank draft on the day selected. Due to the bank's processing time, the actual day a withdrawal is posted to your account could be two or more days after the day selected.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account listed below for all premiums. I understand that initiating automatic payments may result in additional drafts to bring my account current. 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. I further understand that if the date of the withdrawal is after the policy issue date and the premium is not honored, my policy may lapse and require evidence of insurability for reinstatement.

☐ Do not draft initial premium: ☐ Payment enclosed or ☐ Payment collected on delivery

Type of Account: ☐ Checking ☐ Savings

_____ _____ _____
Name of Financial Institution *Routing No. (9-digit number)* *Account No.*

_____ _____
Account Holder's Printed Name (if other than Proposed Insured/Owner) *Relationship (if other than Proposed Insured/Owner)*

_____ _____
Account Holder's Address (Street Address, P.O. Box, City, State, Zip+4) *Name of Authorized Officer (if any)*

_____ ___/___/___ (___) _____
Signature of Account Holder or Authorized Officer *Date (MM/DD/YYYY)* *Telephone No.*

TO ENSURE ACCURACY, SUBMIT VOIDED CHECK
(unless application is submitted electronically)