

SERFF Tracking Number:	SEFL-126851687	State:	Arkansas
Filing Company:	Assurity Life Insurance Company	State Tracking Number:	47008
Company Tracking Number:	REPL HLTH		
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	Repl AR-Hlth		
Project Name/Number:	Repl AR-Hlth/Repl AR-Hlth		

## Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: Repl AR-Hlth

TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other

Filing Type: Form

SERFF Tr Num: SEFL-126851687 State: Arkansas

SERFF Status: Closed-Approved-  
Closed State Tr Num: 47008

Co Tr Num: REPL HLTH

State Status: Approved-Closed

Author: Kristi Hendrickson

Reviewer(s): Rosalind Minor

Date Submitted: 10/07/2010

Disposition Date: 10/12/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Repl AR-Hlth

Project Number: Repl AR-Hlth

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 10/12/2010

Deemer Date:

Submitted By: Kristi Hendrickson

PPACA: Not PPACA-Related

Filing Description:

Form Numbers Form Title

47-352-05051 (R09-10) General Section

Status of Filing in Domicile: Authorized

Date Approved in Domicile:

Domicile Status Comments: Approved

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 10/12/2010

Created By: Kristi Hendrickson

Corresponding Filing Tracking Number:

Assurity Life Insurance Company submits the above captioned form for review and approval. The above stated form is being revised in order to comply with Bulletin 1-2010. The only change being made is rewording of the statement below the replacement question.

Upon approval the above stated form will replace form 47-352-05051 (R05-10) approved July 8, 2010 under filing

SERFF Tracking Number: SEFL-126851687 State: Arkansas  
 Filing Company: Assurity Life Insurance Company State Tracking Number: 47008  
 Company Tracking Number: REPL HLTH  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: Repl AR-Hlth  
 Project Name/Number: Repl AR-Hlth/Repl AR-Hlth  
 number 46120.

PLEASE NOTE THIS IS ONE PAGE OF THE WHOLE APPLICATION IT IS PACKAGED TOGETHER A COPY OF THE SAMPLE APPLICATION IS ATTACHED UNDER SUPPORTING DOCUMENTATION.

## Company and Contact

### Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist policyfiling@assurity.com  
 1526 K Street 402-437-3452 [Phone]  
 Lincoln, NE 68508 402-437-3802 [FAX]

### Filing Company Information

Assurity Life Insurance Company CoCode: 71439 State of Domicile: Nebraska  
 1526 K Street Group Code: -99 Company Type: Life/Health  
 P.O. Box 82533 Group Name: State ID Number:  
 Lincoln, NE 68501-2533 FEIN Number: 38-1843471  
 (800) 276-7619 ext. [Phone]

-----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	\$50.00	10/07/2010	40411458

SERFF Tracking Number: SEFL-126851687 State: Arkansas  
Filing Company: Assurity Life Insurance Company State Tracking Number: 47008  
Company Tracking Number: REPL HLTH  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Repl AR-Hlth  
Project Name/Number: Repl AR-Hlth/Repl AR-Hlth

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/12/2010	10/12/2010

<i>SERFF Tracking Number:</i>	<i>SEFL-126851687</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Assurity Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47008</i>
<i>Company Tracking Number:</i>	<i>REPL HLTH</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Repl AR-Hlth</i>		
<i>Project Name/Number:</i>	<i>Repl AR-Hlth/Repl AR-Hlth</i>		

## **Disposition**

Disposition Date: 10/12/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

*SERFF Tracking Number:* SEFL-126851687      *State:* Arkansas  
*Filing Company:* Assurity Life Insurance Company      *State Tracking Number:* 47008  
*Company Tracking Number:* REPL HLTH  
*TOI:* H21 Health - Other      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* Repl AR-Hlth  
*Project Name/Number:* Repl AR-Hlth/Repl AR-Hlth

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	Yes
<b>Form</b>	General Section	Approved-Closed	Yes

SERFF Tracking Number: SEFL-126851687 State: Arkansas  
 Filing Company: Assurity Life Insurance Company State Tracking Number: 47008  
 Company Tracking Number: REPL HLTH  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: Repl AR-Hlth  
 Project Name/Number: Repl AR-Hlth/Repl AR-Hlth

## Form Schedule

### Lead Form Number: 47-352-05051 (R09-10)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	47-352-05051	Application/General Section Enrollment	Form	Revised	Replaced Form #: 47-352-05051 (R05-10) Previous Filing #: 46120	50.000	47-352-05051_R09-10_.pdf

## 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, provide details below.

b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? .....  Yes  No  
 If YES, and applying for life or health coverage, please complete and return the appropriate State Replacement Form.

Insured's Name	Company Name	Policy No.	Individual (I) 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.?	Employer Paid?
			<input type="checkbox"/> I <input type="checkbox"/> G		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> I <input type="checkbox"/> G		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> I <input type="checkbox"/> G		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

10. If the Proposed Insured is a juvenile, please list the total amount of life insurance in force and pending on all family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
\$	\$	\$	\$	\$	\$	\$



SERFF Tracking Number: SEFL-126851687 State: Arkansas  
 Filing Company: Assurity Life Insurance Company State Tracking Number: 47008  
 Company Tracking Number: REPL HLTH  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: Repl AR-Hlth  
 Project Name/Number: Repl AR-Hlth/Repl AR-Hlth

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	10/12/2010
<b>Comments:</b>			
<b>Attachment:</b>			
READ CERT-H.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Approved-Closed	10/12/2010
<b>Comments:</b>			
<b>Attachment:</b>			
AR.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	10/12/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	10/12/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	10/12/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

## READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word XP program and achieved the following test results:

**Company Name:** Assurity Life Insurance Company

**Type of Form:** Health Application

<b>Form No.</b>	<b>Description</b>	<b>Flesch Score</b>
47-352-05051 (R09-10)	General Section	50.0

  
Signature

October 7, 2010  
Date

Carol S. Watson  
Vice President, General Counsel and Secretary



**PLEASE PRINT IN BLUE OR BLACK INK**

**1. PROPOSED INSURED**

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

Social Security No. Male Female E-mail Age

Home Address: Street Address City State ZIP+4

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.

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

Employer's Address: Street Address City State ZIP+4

Full-time Occupation Duties Part-time Occupation Duties

**2. POLICY OWNERSHIP**

If Ownership is Joint, please list names and relationship to insured.

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

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 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  Annual  Semi-Annual  Quarterly

List Billing (employer)  Automatic Bank Withdrawal  Monthly (not available with Direct Billing)

Payor Name: First Middle Last Billing Address: City State ZIP+4

Secondary Payor Info: First Middle Last Billing Address: City State ZIP+4



TRUST INFORMATION ADDITIONAL BENEFICIARY

For

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, Name of Trustee(s), Tax ID No., Address of Trustee(s), State, ZIP+4

2. BENEFICIARIES

Testamentary Trust (Will) Share %, Living Trust (Please complete information below.) Share %

Name of Living Trust, Date of Trust, Name of Trustee(s), Tax ID No., Address of Trustee(s), Street Address, City, State, ZIP+4

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

Informational Purposes

Table with 6 columns: Primary Beneficiary Name, Relationship, Social Security No., Date of Birth, Share %, Contingent Beneficiary Name, Relationship, Social Security No., Date of Birth, Share %

Only



**GENERAL SECTION**

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or National Reserve?  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 participating in, any hazardous sport or activities?  Yes  No

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

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 or considering a divorce?  Yes  No

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

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

a. Had the driver's license suspended or had the license revoked for cause on a "charge of guilty" conviction for driving while intoxicated (DWI/DWI), or had a criminal conviction for driving while intoxicated?  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, provide details below. If any Proposed Insured is applying for life coverage, complete and return the appropriate State Replacement Form.

b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage?  Yes  No

If Yes and applying for health coverage, please complete and return the appropriate State Replacement Form.

Insured's Name	Company Name	Policy No.	Insured's monthly benefit (or face amount for Life)	Issue Date (MM/DD/YYYY)	DI Coverage Only	
					Coordinates w/ Soc. Sec.?	Employer Paid?
				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

10. If the Proposed Insured is a juvenile, please list the total amount of life insurance in force and pending on all family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
\$	\$	\$	\$	\$	\$	\$



HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 2.

1. Has any Proposed Insured **ever** consulted with or been diagnosed, hospitalized or prescribed medication by a medical professional for any of the following:
  - a. Heart disorder, including a heart attack (*myocardial infarction*), an 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 infectious 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 psychiatric or emotional disorder? .....  Yes  No
  - g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? .....  Yes  No
  - h. Vision impairment, including cataracts, glaucoma, or any other eye disorder? .....  Yes  No
  - i. A hearing impairment, including deafness or any other hearing disorder? .....  Yes  No
  - j. Any chronic illness, injury, or condition requiring medical attention, including blood transfusion? .....  Yes  No
2.
  - a. Ever prescribed any medication, including psychoactive drugs, if any, by a medical professional? .....  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, Proposed Insured, disorder and age at death). .....  Yes  No  
 \_\_\_\_\_
5.
  - a. Has any Proposed Insured **ever** had any disorder of any genital or reproductive system, 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.





PHYSICIAN INFORMATION

For

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 attached thereto.

- I (We) agree that the information provided in this application is true and correct.
- a. In the event that the information provided in this application is not true and correct, the insurance company may rescind the policy and refuse to pay any claims.
- b. In the event that the information provided in this application is not true and correct, the insurance company may rescind the policy and refuse to pay any claims.
- 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 \_\_\_\_\_ or \_\_\_\_\_  
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.

Only



FIELD UNDERWRITER'S STATEMENT

- 1. a. What amount was collected with this application? \$
b. Has a Temporary Conditional Insurance Agreement been given to the policy owner?
c. Has the Proposed Insured signed a Confidential Information Agreement and been given a Consumer Notice?
2. a. Did you personally see all Proposed Insured(s) on the date of application?
b. How well do you know the Proposed Insured(s)?
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.

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made.
Agent is responsible for scheduling exam items.
NOTE: ANY PREFERRED PLANS REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.
Paramedical examination Blood Sample Urine Sample Electrocardiogram (EKG) Treadmill EKG Medical exam by physician

- 4. Is other insurance coverage in force for any Proposed Insured?
5. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage?
6. Was sales material used in soliciting this application?
7. Was the sales material left with the applicant?
8. Was the sales material approved by Assurity Life Insurance Company?

9. Are commissions to be split? Yes No Agent No. % Agent No. %

- AUTOMATIC PAYMENT OPTIONS
Supplemental premium for the insured's spouse or dependent child
Additional premium for other dependent family members
Supplemental premium for other dependent family members

- LIST ALL
Supplemental premium for other dependent family members
Additional premium for other dependent family members

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 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 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 information furnished on this 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