

**State:** Arkansas **Filing Company:** Assurity Life Insurance Company  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Misc 2012 Hlth  
**Project Name/Number:** Misc 2012 Hlth/Misc 2012 Hlth

## Filing at a Glance

Company: Assurity Life Insurance Company  
Product Name: Misc 2012 Hlth  
State: Arkansas  
TOI: H21 Health - Other  
Sub-TOI: H21.000 Health - Other  
Filing Type: Form  
Date Submitted: 01/18/2013  
SERFF Tr Num: SEFL-128853229  
SERFF Status: Closed-Approved  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 2012 MISC HLTH  
  
Implementation: On Approval  
Date Requested:  
Author(s): Kristi Hendrickson  
Reviewer(s): Donna Lambert (primary)  
Disposition Date: 01/28/2013  
Disposition Status: Approved  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** Assurity Life Insurance Company  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Misc 2012 Hlth  
**Project Name/Number:** Misc 2012 Hlth/Misc 2012 Hlth

## General Information

Project Name: Misc 2012 Hlth Status of Filing in Domicile: Authorized  
 Project Number: Misc 2012 Hlth Date Approved in Domicile: 01/11/2013  
 Requested Filing Mode: Review & Approval Domicile Status Comments: Approved  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Individual Market Type:  
 Overall Rate Impact: Filing Status Changed: 01/28/2013  
 State Status Changed: 01/28/2013  
 Deemer Date: Created By: Kristi Hendrickson  
 Submitted By: Kristi Hendrickson Corresponding Filing Tracking Number: SEFL-128853240  
 PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

### Filing Description:

#### Form Number Form Title

75-315-02201 (R08-12) Guaranteed Insurability Insurance Application  
 75-500-05055 (R11-12) Confidential Information Authorization  
 75-502-05055 (R11-12) Confidential Information Authorization for Release of Psychotherapy Notes  
 75-504-05055 Confidential Information Authorization  
 75-803-02255 (R07-12) Temporary Conditional Insurance Agreement  
 75-819-05055 (R08-12) Tobacco Use Questionnaire  
 75-851-05055 (R11-12) Application for Reinstatement  
 75-859-05051 (R11-12) Evidence of Insurability

The above forms are submitted for review and approval.

When approved, the above forms will replace the forms as indicated on the form schedule.

Form 75-315-02201 (R08-12), Guaranteed Insurability Insurance Application: This form is utilized when applying for additional disability income insurance as provided by contract language. It is used with individual disability income products. The main change made from the previous version is the addition of the fraud notice.

Form 75-500-05055 (R11-12), Confidential Information Authorization: This form is utilized when a release to obtain medical information is needed. It is used with individual life and health products that are fully underwritten.

Form 75-502-05055 (R11-12), Confidential Information Authorization for Release of Psychotherapy Notes: This form is utilized when a release to obtain psychotherapy notes is needed. It is used with individual life and health products.

Form 75-504-05055, Confidential Information Authorization: This form is utilized when a release to obtain medical information is needed. It is used with individual life and health products that have simplified underwriting.

Form 75-803-02255 (R07-12), Temporary Conditional Insurance Agreement: This form is utilized when a premium payment is included with an application for individual health coverage.

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Form 75-819-05055 (R08-12), Tobacco Use Questionnaire: This form is utilized when applying for non-tobacco rates on an in-force policy that was issued at tobacco rates. It is used with individual life and health products. The main change made from the previous version is the addition of the fraud notice.

Form 75-851-05055 (R11-12), Application for Reinstatement: This form is utilized for reinstatement of all individual life and health insurance products, except Direct mail. The main change made from the previous version is the addition of the fraud notice.

Form 75-859-05051 (R11-12), Evidence of Insurability: This form is utilized when a policy owner wants make changes to (such as increasing) their in force coverage. It is used with individual life and health products.

Please note that this filing and filing SEFL-128853240 submitted on the life side contain some of the same forms. Therefore, we ask that they be reviewed simultaneously. Thank you!

## Company and Contact

### Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist policyfiling@assurity.com  
 P.O. Box 82533 402-437-3452 [Phone]  
 Lincoln, NE 68501-2533 402-437-3802 [FAX]

### Filing Company Information

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

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$400.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Assurity Life Insurance Company	\$400.00	01/18/2013	66675084

**SERFF Tracking #:**

SEFL-128853229

**State Tracking #:****Company Tracking #:**

2012 MISC HLTH

**State:**

Arkansas

**Filing Company:**

Assurity Life Insurance Company

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

Misc 2012 Hlth

**Project Name/Number:**

Misc 2012 Hlth/Misc 2012 Hlth

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/28/2013	01/28/2013

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Guaranteed Insurability Insurance Application	Kristi Hendrickson	01/22/2013	01/22/2013
Form	Tobacco Use Questionnaire	Kristi Hendrickson	01/22/2013	01/22/2013
Form	Application for Reinstatement	Kristi Hendrickson	01/22/2013	01/22/2013
Form	Evidence of Insurability	Kristi Hendrickson	01/22/2013	01/22/2013

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Misc 2012 Hlth  
**Project Name/Number:** Misc 2012 Hlth/Misc 2012 Hlth

**Filing Company:** Assurity Life Insurance Company

## Disposition

Disposition Date: 01/28/2013

Implementation Date:

Status: Approved

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Form (revised)	Guaranteed Insurability Insurance Application	Approved	Yes
Form	Guaranteed Insurability Insurance Application	Replaced	Yes
Form	Confidential Information Authorization	Approved	Yes
Form	Confidential Information Authorization for Release of Psychotherapy Notes	Approved	Yes
Form	Confidential Information Authorization	Approved	Yes
Form	Temporary Conditional Insurance Agreement	Approved	Yes
Form (revised)	Tobacco Use Questionnaire	Approved	Yes
Form	Tobacco Use Questionnaire	Replaced	Yes
Form (revised)	Application for Reinstatement	Approved	Yes

SERFF Tracking #:

SEFL-128853229

State Tracking #:

Company Tracking #:

2012 MISC HLTH

State:

Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI:

H21 Health - Other/H21.000 Health - Other

Product Name:

Misc 2012 Hlth

Project Name/Number:

Misc 2012 Hlth/Misc 2012 Hlth

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Application for Reinstatement	Replaced	Yes
Form (revised)	Evidence of Insurability	Approved	Yes
Form	Evidence of Insurability	Replaced	Yes

**SERFF Tracking #:**

SEFL-128853229

**State Tracking #:**

**Company Tracking #:**

2012 MISC HLTH

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**State:**

Arkansas

**Filing Company:**

Assurity Life Insurance Company

**TOI/Sub-TOI:**

H21 Health - Other/H21.000 Health - Other

**Product Name:**

Misc 2012 Hlth

**Project Name/Number:**

Misc 2012 Hlth/Misc 2012 Hlth

## Amendment Letter

Submitted Date:

01/22/2013

Comments:

Some of the forms loaded did not contain the AR state specific fraud warning. That has been corrected.

Changed Items:

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: Misc 2012 Hlth  
 Project Name/Number: Misc 2012 Hlth/Misc 2012 Hlth

Filing Company: Assurity Life Insurance Company

### Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Guaranteed Insurability Insurance Application	47-315-02201 (R08-12)	AEF	Revised	Replaced Form #:75-315-02201 Previous Filing #:SEFL-126646812	50.100	47-315-02201 (R08-12).pdf	Date Submitted: 01/22/2013 By:
<i>Previous Version</i>								
1	Guaranteed Insurability Insurance Application	75-315-02201 (R08-12)	AEF	Revised	Replaced Form #:75-315-02201 Previous Filing #:SEFL-126646812	50.100	75-315-02201 (R08-12).pdf	Date Submitted: 01/18/2013 By: Kristi Hendrickson
2	Tobacco Use Questionnaire	47-819-05055 (R08-12)	OTH	Revised	Replaced Form #:75-819-05055 Previous Filing #:SEFL-126646812	53.700	47-819-05055 (R08-12).pdf	Date Submitted: 01/22/2013 By:
<i>Previous Version</i>								
2	Tobacco Use Questionnaire	75-819-05055 (R08-12)	OTH	Revised	Replaced Form #:75-819-05055 Previous Filing #:SEFL-126646812	53.700	75-819-05055 (R08-12).pdf	Date Submitted: 01/18/2013 By: Kristi Hendrickson
3	Application for Reinstatement	47-851-05055 (R11-12)	AEF	Revised	Replaced Form #:75-851-05055 Previous Filing #:SEFL-126036705	50.800	47-851-05055 (R11-12).pdf	Date Submitted: 01/22/2013 By:
<i>Previous Version</i>								

SERFF Tracking #:

SEFL-128853229

State Tracking #:

Company Tracking #:

2012 MISC HLTH

State: Arkansas  
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 Product Name: Misc 2012 Hlth  
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Filing Company: Assurity Life Insurance Company

### Form Schedule Item Changes:

Form Schedule Item Changes								
3	Application for Reinstatement	75-851-05055 (R11-12)	AEF	Revised	Replaced Form #:75-851-05055 Previous Filing #:SEFL-126036705	50.800	75-851-05055 (R11-12).pdf	Date Submitted: 01/18/2013 By: Kristi Hendrickson
4	Evidence of Insurability	47-859-05051 (R11-12)	OTH	Revised	Replaced Form #:75-859-05051 Previous Filing #:SEFL-126217550	55.500	47-859-05051 (R11-12).pdf	Date Submitted: 01/22/2013 By:
<i>Previous Version</i>								
4	Evidence of Insurability	75-859-05051 (R11-12)	OTH	Revised	Replaced Form #:75-859-05051 Previous Filing #:SEFL-126217550	55.500	75-859-05051 (R11-12).pdf	Date Submitted: 01/18/2013 By: Kristi Hendrickson

No Rate Schedule Items Changed.

No Supporting Documents Changed.

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: Misc 2012 Hlth  
 Project Name/Number: Misc 2012 Hlth/Misc 2012 Hlth

Filing Company: Assurity Life Insurance Company

## Form Schedule

Lead Form Number: 75-315-02201 (R08-12)									
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved 01/28/2013	Guaranteed Insurability Insurance Application	47-315-02201 (R08-12)	AEF	Revised	Previous Filing Number:	SEFL-126646812	50.100	47-315-02201 (R08-12).pdf
						Replaced Form Number:	75-315-02201		
2	Approved 01/28/2013	Confidential Information Authorization	75-500-05055 (R11-12)	OTH	Revised	Previous Filing Number:	SEFL-125334216	50.500	75-500-05055 (R11-12).pdf
						Replaced Form Number:	75-500-05055		
3	Approved 01/28/2013	Confidential Information Authorization for Release of Psychotherapy Notes	75-502-05055 (R11-12)	OTH	Initial			50.700	75-502-05055 (R11-12).pdf
4	Approved 01/28/2013	Confidential Information Authorization	75-504-05055	OTH	Initial			50.100	75-504-05055 (R11-12).pdf
5	Approved 01/28/2013	Temporary Conditional Insurance Agreement	75-803-02255 (R07-12)	OTH	Revised	Previous Filing Number:	SEFL-126646812	51.000	75-803-02255(R07-12).pdf
						Replaced Form Number:	75-803-02255		
6	Approved 01/28/2013	Tobacco Use Questionnaire	47-819-05055 (R08-12)	OTH	Revised	Previous Filing Number:	SEFL-126646812	53.700	47-819-05055 (R08-12).pdf
						Replaced Form Number:	75-819-05055		

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Misc 2012 Hlth  
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**Filing Company:** Assurity Life Insurance Company

**Lead Form Number: 75-315-02201 (R08-12)**

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
						Previous Filing Number:	Replaced Form Number:		
7	Approved 01/28/2013	Application for Reinstatement	47-851-05055 (R11-12)	AEF	Revised	Previous Filing Number:	SEFL-126036705	50.800	47-851-05055 (R11-12).pdf
						Replaced Form Number:	75-851-05055		
8	Approved 01/28/2013	Evidence of Insurability	47-859-05051 (R11-12)	OTH	Revised	Previous Filing Number:	SEFL-126217550	55.500	47-859-05051 (R11-12).pdf
						Replaced Form Number:	75-859-05051		

**Form Type Legend:**

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages







\_\_\_\_\_  
*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			
<i>Legal Name</i>	<i>Date of Birth</i>	<i>Legal Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

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 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 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**





\_\_\_\_\_  
*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				
<i>Legal Name</i>	<i>Date of Birth</i>	<i>Legal Name</i>	<i>Date of Birth</i>	
_____	_____	_____	_____	
_____	_____	_____	_____	

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)*

\_\_\_\_\_  
*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**





\_\_\_\_\_  
*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			
<i>Legal Name</i>	<i>Date of Birth</i>	<i>Legal Name</i>	<i>Date of Birth</i>
_____	_____	_____	_____
_____	_____	_____	_____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or MIB Inc. (*formerly known as the Medical Information Bureau*) 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. A photographic copy of this authorization shall be as valid as the original. This authorization is valid for twenty-four (24) months from the date of signature below. 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.

By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

**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)*







Insured's Name \_\_\_\_\_ Policy No. \_\_\_\_\_  
*First Middle Last*

During the past **12 months**, have you smoked cigarettes? .....  Yes  No

During the past **12 months**, have you used any form of tobacco, nicotine-based products or substitutes such as patches or gum? .....  Yes  No

If YES, please list type(s) \_\_\_\_\_

If you have quit smoking or quit using tobacco in any form, please provide the date you quit \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (MM/DD/YYYY)

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.**

I have read the above questions and declare that the answers are complete and true to the best of my knowledge and belief.

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

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





**PROPOSED INSURED**

<i>First</i>	<i>Middle</i>	<i>Last</i>	Policy No.	
Legal Name				
<i>Street Address</i>		<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Home Address				
Policyowner's Social Security No.			Personal Phone No. (      )	
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number _____				
Is the Proposed Insured currently working at least 30 hours per week in primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of employment _____ / _____ <small>Years/Months</small>				
Occupation _____ Duties _____				

**STATEMENT OF HEALTH**

**Complete the following questions for all persons covered under this policy. Provide details to any YES answers in Supplemental Section 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. Chest pain, heart attack, irregular heartbeat, coronary heart disease, stroke, transient ischemic attack (*TIA or mini-stroke*), aneurysm, any disease or disorder of the circulatory system or elevated cholesterol? .....  Yes  No

b. Any disease or disorder of the thyroid, pancreas, liver, kidney (*other than kidney stones*), stomach, gall bladder, bladder or prostate, genitourinary system, intestinal or digestive tract, ulcerative colitis, lupus, anemia or any other blood disorder? .....  Yes  No

c. Polyp, mole, lump or other growth, breast disorder or abnormal mammogram, biopsy or abnormal prostate specific antigen (*PSA*) test, 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, multiple sclerosis (*MS*), muscular dystrophy (*MD*), Parkinson's disease, amyotrophic lateral sclerosis (*ALS*), any brain or nervous system disorder, cerebral palsy (*CP*) or any form of muscular atrophy? .....  Yes  No

e. Chronic obstructive pulmonary disease (*COPD*), emphysema, shortness of breath, asthma, sleep apnea or other respiratory disorder? .....  Yes  No

f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? .....  Yes  No

g. Rheumatoid or osteoarthritis, or any disease or disorder of the back, spine, bones, joints or muscles? .....  Yes  No

h. Been advised to have surgery, treatments or testing which have not been completed, or been aware of any symptoms or complaints regarding their health for which they have not yet consulted a physician? .....  Yes  No

i. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related*) or urine tests? .....  Yes  No

j. Been admitted to any hospital or psychiatric facility, received home health care or been unable to complete the activities of daily living: bathing, dressing, grooming, toileting, transferring, mobility, eating, etc.? .....  Yes  No

k. Used marijuana or any illegal or addictive drugs, or been advised to seek treatment or sought treatment for alcoholism, drug addiction, drug abuse or other substance abuse? .....  Yes  No

2. Has any Proposed Insured during the past **5 years** participated in, or is any Proposed Insured planning within the next **12 months** to participate in, any hazardous sport or activities? .....  Yes  No  
 If YES to any of the following, please check all that apply, and complete and return the Avocation Questionnaire.

<input type="checkbox"/> Skin/Scuba Diving	<input type="checkbox"/> Bungee Jumping	<input type="checkbox"/> Skydiving/Parachuting/Hang Gliding	<input type="checkbox"/> Rodeo
<input type="checkbox"/> Motor-powered Racing	<input type="checkbox"/> Boxing	<input type="checkbox"/> Professional, Semi-professional or Club Sports	
<input type="checkbox"/> Cave Exploration	<input type="checkbox"/> Hot Air Ballooning	<input type="checkbox"/> Mountain/Rock/Ice Climbing	

3. In the past **12 months**, has any person used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? .....  Yes  No  
 If YES, please list type \_\_\_\_\_ and last date of use (*MM/DD/YYYY*) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



**STATEMENT OF HEALTH (continued)**

4. During the past **5 years**, has any Proposed Insured had their driver's license suspended or revoked, been convicted of or pleaded "guilty" or "no contest" to driving under the influence (*DUI/DWI*), or had more than 3 moving violations? .....  Yes  No

5. Has any Proposed Insured been convicted of a felony, or is any Proposed Insured currently on probation? .....  Yes  No

6. Is any Proposed Insured currently pregnant? .....  Yes  No

If YES, please give due date (*MM/DD/YYYY*) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

7. 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

8. Within the past **12 months**, has any Proposed Insured been prescribed medication?.....  Yes  No

**SUPPLEMENTAL INFORMATION**

**Enter complete details to questions 1-7 (if answered YES). In addition, please list all medications prescribed for any Proposed Insured in the last 12 months and why they were prescribed. If additional space is needed, attach a separate sheet of paper.**

Question #/Letter	Name (First, Middle, Last)	Onset Date (MM/DD/YYYY)	Duration (Days, Months, Years)	Health Condition and Details	Name of Medication, Dosage and Frequency	Date Last Taken (MM/DD/YYYY)	Medical Care Provider's Name/Address/Phone

**REPRESENTATION**

**I represent** that these statements are true and complete to the best of my knowledge and belief. **I understand and agree** that the Company shall not incur any liability under this application until reinstatement is approved by the Company. **I hereby acknowledge** that I have read and understand the fraud information given below.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

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

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

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

\_\_\_\_\_  
Signature of Owner (if other than Insured)

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

\_\_\_\_\_  
Signature of Proposed Joint Insured





**PRIMARY INSURED**

<i>First</i>	<i>Middle</i>	<i>Last</i>	Policy No.
Legal Name			

<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Home Address			

**GENERAL SECTION**

Please answer the following questions for any person to be insured: If more space is needed, please provide details on page 4.

1. Does any Insured belong to or intend to join the National Guard or military? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_

2. During the past **5 years** or within the next **12 months** (If YES to any of the following, please complete and return the Avocation Questionnaire):

a. Has any Insured flown other than as a fare-paying passenger, or is any Insured contemplating flying as a pilot, crew member or student? .....  Yes  No

b. Has any 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 Insured contemplate residence or travel outside of the United States? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_

4. During the past **12 months**, has any Insured had a change in weight of more than 10 pounds? .....  Yes  No  
 If YES, please list the Insured's name, amount of weight change and reason for change:  
 \_\_\_\_\_

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

a. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined, 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 Insured currently negotiating for other insurance coverage? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_

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

a. Had their driver's license suspended or revoked, been convicted of or pleaded "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 Insured currently on probation? .....  Yes  No  
 If YES, please list the Insured's name, reason for probation and length of probationary period:  
 \_\_\_\_\_

9. Does any Insured have other insurance coverage in force? .....  Yes  No  
 If YES, please provide details below. If applying for life coverage, complete and return the appropriate State Replacement Form.

Company Name	Policy No.	Individual (I) Group (G)	Benefits (mo. benefit and benefit period for DI or face amt. 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

**HEALTH SECTION**

Please answer the following questions. If YES to any of the following, please provide details on page 3.

- 1. Has any 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 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 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. a. Has any Insured **ever** had any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? .....  Yes  No  
b. Is any Insured currently pregnant? .....  Yes  No  
If YES, date child is expected (*MM/DD/YYYY*) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- 5. Has any 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 Insured, disorder and age at death. ....  Yes  No  
\_\_\_\_\_

**DETAILS:** Enter complete details from questions #1-4 on page 3. If more space is needed, attach additional Supplemental Information form.



Information	Payor	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	<input type="checkbox"/> Male <input type="checkbox"/> Female				
Height/Weight	ft. in. / lbs.				
Residing with Primary Insured			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Primary Insured					
Employer					
Occupation					
Duties					
Gross monthly income	\$	\$			
If self-employed, net mo. income	\$	\$			

Has the Payor/Spouse ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? .....  Yes  No  
 (Not applicable to Child Riders.)

If YES, please list person(s), type and last date of use (MM/DD/YYYY) \_\_\_\_\_ / /  
 \_\_\_\_\_ / /

**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
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			



**REPRESENTATION**

**I represent** that these statements are true and complete to the best of my knowledge and belief. **I understand and agree** that the Company shall not incur any liability under this application until the application this is attached to is approved by the Company. **I hereby acknowledge** that I have read and understand the fraud information given below.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

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

\_\_\_\_\_  
Signature of Insured

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

\_\_\_\_\_  
Signature of Owner (if other than Insured)

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

\_\_\_\_\_  
Signature of Joint Insured



SERFF Tracking #:

SEFL-128853229

State Tracking #:

Company Tracking #:

2012 MISC HLTH

State: Arkansas  
 TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other  
 Product Name: Misc 2012 Hlth  
 Project Name/Number: Misc 2012 Hlth/Misc 2012 Hlth

Filing Company: Assurity Life Insurance Company

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/28/2013
Comments:			
Attachment(s):			
Readability Certification-Health.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	01/28/2013
Bypass Reason:	N/A		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	01/28/2013
Bypass Reason:	N/A		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	01/28/2013
Bypass Reason:	N/A		
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved	01/28/2013
Bypass Reason:	N/A		

## 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

**Form Number(s):** Health Application Forms

**Type of Form:** Application

<b>Form No.</b>	<b>Description</b>	<b>Flesch Score</b>
75-315-02201 (R08-12)	Guaranteed Insurability Insurance Application	50.1
75-500-05055 (R11-12)	Confidential Information Authorization	50.5
75-502-05055 (R11-12)	Confidential Information Authorization for Release of Psychotherapy Notes	50.7
75-504-05055	Confidential Information Authorization	50.1
75-803-02255 (R07-12)	Temporary Conditional Insurance Agreement	51.0
75-819-05055 (R08-12)	Tobacco Use Questionnaire	53.7
75-851-05055 (R11-12)	Application for Reinstatement	50.8
75-859-05051 (R11-12)	Evidence of Insurability	55.5

  
Signature

January 18, 2013  
Date

Carol S. Watson  
Vice President, General Counsel & Secretary

**State:** Arkansas  
**TOI/Sub-TOI:** H21 Health - Other/H21.000 Health - Other  
**Product Name:** Misc 2012 Hlth  
**Project Name/Number:** Misc 2012 Hlth/Misc 2012 Hlth

**Filing Company:** Assurity Life Insurance Company

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/16/2013	Replaced 01/28/2013	Form	Guaranteed Insurability Insurance Application	01/22/2013	75-315-02201 (R08-12).pdf (Superseded)
01/16/2013	Replaced 01/28/2013	Form	Tobacco Use Questionnaire	01/22/2013	75-819-05055 (R08-12).pdf (Superseded)
01/16/2013	Replaced 01/28/2013	Form	Application for Reinstatement	01/22/2013	75-851-05055 (R11-12).pdf (Superseded)
01/16/2013	Replaced 01/28/2013	Form	Evidence of Insurability	01/22/2013	75-859-05051 (R11-12).pdf (Superseded)







**PROPOSED INSURED**

<b>Legal Name</b>	<i>First</i>	<i>Middle</i>	<i>Last</i>	<b>Policy No.</b>
<b>Home Address</b>	<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>ZIP+4</i>
<b>Policyowner's Social Security No.</b>			<b>Personal Phone No.</b> (      )	
Does the Proposed Insured have a valid driver's license? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list state of issue and number _____				
Is the Proposed Insured currently working at least 30 hours per week in primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No Length of employment _____ / _____ <small style="float: right;">Years/Months</small>				
Occupation _____ Duties _____				

**STATEMENT OF HEALTH**

**Complete the following questions for all persons covered under this policy. Provide details to any YES answers in Supplemental Section on page 2.**

1. During the past **10 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:

a. Chest pain, heart attack, irregular heartbeat, coronary heart disease, stroke, transient ischemic attack (*TIA or mini-stroke*), aneurysm, any disease or disorder of the circulatory system or elevated cholesterol? .....  Yes  No

b. Any disease or disorder of the thyroid, pancreas, liver, kidney (*other than kidney stones*), stomach, gall bladder, bladder or prostate, genitourinary system, intestinal or digestive tract, ulcerative colitis, lupus, anemia or any other blood disorder? .....  Yes  No

c. Polyp, mole, lump or other growth, breast disorder or abnormal mammogram, biopsy or abnormal prostate specific antigen (*PSA*) test, 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, multiple sclerosis (*MS*), muscular dystrophy (*MD*), Parkinson's disease, amyotrophic lateral sclerosis (*ALS*), any brain or nervous system disorder, cerebral palsy (*CP*) or any form of muscular atrophy? .....  Yes  No

e. Chronic obstructive pulmonary disease (*COPD*), emphysema, shortness of breath, asthma, sleep apnea or other respiratory disorder? .....  Yes  No

f. Dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? .....  Yes  No

g. Rheumatoid or osteoarthritis, or any disease or disorder of the back, spine, bones, joints or muscles? .....  Yes  No

h. Been advised to have surgery, treatments or testing which have not been completed, or been aware of any complaints regarding their health for which they have not yet consulted a physician? .....  Yes  No

i. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests (*other than AIDS-related*) or urine tests? .....  Yes  No

j. Been admitted to any hospital or psychiatric facility, received home health care or been unable to complete the activities of daily living: bathing, dressing, grooming, toileting, transferring, mobility, eating, etc.? .....  Yes  No

k. Used marijuana or any illegal or addictive drugs, or been advised to seek treatment or sought treatment for alcoholism, drug addiction, drug abuse or other substance abuse? .....  Yes  No

2. Has any Proposed Insured during the past **5 years** participated in, or is any Proposed Insured planning within the next **12 months** to participate in, any of the following hazardous sport or activities? .....  Yes  No  
 If YES to any of the following, please check all that apply, and complete and return the Avocation Questionnaire.

<input type="checkbox"/> Skin/Scuba Diving	<input type="checkbox"/> Bungee Jumping	<input type="checkbox"/> Skydiving/Parachuting/Hang Gliding	<input type="checkbox"/> Rodeo
<input type="checkbox"/> Hot Air Ballooning	<input type="checkbox"/> Boxing	<input type="checkbox"/> Professional, Semi-professional or Club Sports	
<input type="checkbox"/> Cave Exploration	<input type="checkbox"/> Mountain/Rock/Ice Climbing	<input type="checkbox"/> Motor-powered Organized Racing	

3. In the past **12 months**, has any person used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? .....  Yes  No  
 If YES, please list type \_\_\_\_\_ and last date of use (*MM/DD/YYYY*) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



**STATEMENT OF HEALTH (continued)**

4. During the past **5 years**, has any Proposed Insured had their driver's license suspended or revoked, been convicted of or pleaded "guilty" or "no contest" to driving under the influence (DUI/DWI), or had more than 3 moving violations? .....  Yes  No

5. Has any Proposed Insured been convicted of a felony, or is any Proposed Insured currently on probation? .....  Yes  No

6. Is any Proposed Insured currently pregnant? .....  Yes  No  
If YES, please give due date (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

7. During the past **10 years**, has any Proposed Insured been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or antibodies to human T-lymphotropic virus type III (HTLV); or had a positive test for human immunodeficiency virus (HIV) antibodies? .....  Yes  No

8. Within the past **12 months**, has any Proposed Insured been prescribed medication?.....  Yes  No

**SUPPLEMENTAL INFORMATION**

**Enter complete details to questions 1-7 (if answered YES). In addition, please list all medications prescribed for any Proposed Insured in the last 12 months and why they were prescribed. If additional space is needed, attach a separate sheet of paper.**

Question #/Letter	Name (First, Middle, Last)	Onset Date (MM/DD/YYYY)	Duration (Days, Months, Years)	Health Condition and Details	Name of Medication, Dosage and Frequency	Date Last Taken (MM/DD/YYYY)	Medical Care Provider's Name/Address/Phone

**REPRESENTATION**

**I represent** that these statements are true and complete to the best of my knowledge and belief. **I understand and agree** that the Company shall not incur any liability under this application until reinstatement is approved by the Company. **I hereby acknowledge** that I have read and understand the fraud information given below.

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.

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

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

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

\_\_\_\_\_  
Signature of Owner (if other than Insured)

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

\_\_\_\_\_  
Signature of Proposed Joint Insured





**PLEASE PRINT WITH BLACK INK**

PRIMARY INSURED				
Legal Name	<i>First</i>	<i>Middle</i>	<i>Last</i>	Policy No.
Home Address	<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>ZIP+4</i>

**GENERAL SECTION**

Please answer the following questions for any person to be insured: If more space is needed, please provide details on page 4.

1. Does any Insured belong to or intend to join the National Guard or military? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  
2. During the past **5 years** or within the next **12 months** (If YES to any of the following, please complete and return the Avocation Questionnaire):
  - a. Has any Insured flown other than as a fare-paying passenger, or is any Insured contemplating flying as a pilot, crew member or student? .....  Yes  No
  - b. Has any Insured participated in, or contemplated participation in, any of the following hazardous sport or activities? .....  Yes  No  
 If YES, check all that apply:     Skin/Scuba Diving                       Bungee Jumping                       Skydiving/Parachuting/Hang Gliding  
 Hot Air Ballooning                       Boxing                       Rodeo                       Professional, Semi-professional or Club Sports  
 Cave Exploration                       Mountain/Rock/Ice Climbing                       Motor-powered Organized Racing
  
3. During the next **12 months**, does any Insured contemplate residence or travel outside of the United States? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  
4. During the past **12 months**, has any Insured had a change in weight of more than 10 pounds? .....  Yes  No  
 If YES, please list the Insured's name, amount of weight change and reason for change:  
 \_\_\_\_\_
  
5. During the past **5 years**, has any Insured:
  - a. Had a life, health or hospital expense insurance application postponed, rated up, rideder or declined, 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 Insured currently negotiating for other insurance coverage? .....  Yes  No  
 If YES, please explain: \_\_\_\_\_
  
7. During the past **5 years**, has any Insured:
  - a. Had their driver's license suspended or revoked, been convicted of or pleaded "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 Insured currently on probation? .....  Yes  No  
 If YES, please list the Insured's name, reason for probation and length of probationary period:  
 \_\_\_\_\_
  
9. Does any Insured have other insurance coverage in force? .....  Yes  No  
 If YES, please provide details below. If applying for life coverage, complete and return the appropriate State Replacement Form.

Company Name	Policy No.	Individual (I) Group (G)	Benefits (mo. benefit and benefit period for DI or face amt. 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



**HEALTH SECTION**

Please answer the following questions. If YES to any of the following, please provide details on page 3.

- 1. During the past **10 years**, has any 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 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 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. a. During the past **10 years**, has any Insured **ever** had any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? .....  Yes  No
- b. Is any Insured currently pregnant? .....  Yes  No
- If YES, date child is expected (MM/DD/YYYY) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- 5. Has any 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 Insured, disorder and age at death. ....  Yes  No

**DETAILS:** Enter complete details from questions #1-4 on page 3. If more space is needed, attach additional Supplemental Information form.

Information	Payor	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	<input type="checkbox"/> Male <input type="checkbox"/> Female				
Height/Weight	ft. in. / lbs.				
Residing with Primary Insured			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Primary Insured					
Employer					
Occupation					
Duties					
Gross monthly income	\$	\$			
If self-employed, net mo. income	\$	\$			

Has the Payor/Spouse ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? .....  Yes  No  
*(Not applicable to Child Riders.)*

If YES, please list person(s), type and last date of use (MM/DD/YYYY) \_\_\_\_\_ / /  
 \_\_\_\_\_ / /

**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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		/ /			
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		/ /			
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		/ /			
		/ /			



**REPRESENTATION**

**I represent** that these statements are true and complete to the best of my knowledge and belief. **I understand and agree** that the Company shall not incur any liability under this application until the application this is attached to is approved by the Company. **I hereby acknowledge** that I have read and understand the fraud information given below.

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.

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

\_\_\_\_\_  
Signature of Insured

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

\_\_\_\_\_  
Signature of Owner (if other than Insured)

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

\_\_\_\_\_  
Signature of Joint Insured

