

State: Arkansas **Filing Company:** Assurity Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Misc 2012 Life
Project Name/Number: Misc 2012 Life/Misc 2012 Life

Filing at a Glance

Company: Assurity Life Insurance Company
Product Name: Misc 2012 Life
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 01/18/2013
SERFF Tr Num: SEFL-128853240
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: MISC 2012 LIFE

Implementation: On Approval
Date Requested:
Author(s): Kristi Hendrickson
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/23/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: Misc 2012 Life
 Project Name/Number: Misc 2012 Life/Misc 2012 Life

Filing Company: Assurity Life Insurance Company

General Information

Project Name: Misc 2012 Life	Status of Filing in Domicile: Authorized
Project Number: Misc 2012 Life	Date Approved in Domicile: 01/14/2013
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: 01/23/2013
	State Status Changed: 01/23/2013
Deemer Date:	Created By: Kristi Hendrickson
Submitted By: Kristi Hendrickson	Corresponding Filing Tracking Number: SEFL-128853229

Filing Description:

Form Number Form Title
 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
 75-802-05055 (R07-12) Temporary Conditional Insurance Agreement
 75-819-05055 (R08-12) Tobacco Use Questionnaire
 75-851-05055 (R11-12) Application for Reinstatement
 75-852-01052 (R11-12) Assurity Direct Only Application for Reinstatement
 75-859-05051 (R11-12) Evidence of Insurability
 75-883-05055 Application for Conversion
 47-355-05051 (R12-12) Life Product Section
 47-357-05051 (R09-12) Universal Life Product Section

The above forms are submitted for review and approval.

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

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.

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 75-802-05055 (R07-12), Temporary Conditional Insurance Agreement: This form is utilized when a premium payment is included with an application for individual life or reversionary annuity coverage.

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

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health insurance products, except Direct mail. The main change made from the previous version is the addition of the fraud notice.

Form 75-852-01052 (R11-12), Assurity Direct Only Application for Reinstatement: This form is utilized for reinstatement of our Direct mail life or health insurance products. 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.

Form 75-883-05055, Application for Conversion: This form is utilized to convert individual and group term life insurance to one of our permanent life insurance plans.

Form 47-355-05051 (R12-12), Life Product Section: This form is utilized when applying for our fully underwritten individual term life, whole life and single premium whole life products. The main change to the form is the addition of the three health questions on page 2 regarding the proposed insured children.

Form 47-357-05051 (R09-12), Universal Life Product Section: This form is utilized when applying for our fully underwritten universal life product. The main change to the form is the addition of the three health questions regarding the proposed insured children.

Please note that this filing and filing SEFL-128853229 submitted on the health 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:	\$550.00
Retaliatory?	No
Fee Explanation:	\$50 per form
Per Company:	No

Company	Amount	Date Processed	Transaction #
Assurity Life Insurance Company	\$550.00	01/18/2013	66675067

SERFF Tracking #:

SEFL-128853240

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

MISC 2012 LIFE

State:

Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Misc 2012 Life

Project Name/Number:

Misc 2012 Life/Misc 2012 Life

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/23/2013	01/23/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
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	Assurity Direct Only Application for Reinstatement	Kristi Hendrickson	01/22/2013	01/22/2013
Form	Evidence of Insurability	Kristi Hendrickson	01/22/2013	01/22/2013
Form	Life Product Section	Kristi Hendrickson	01/22/2013	01/22/2013
Form	Universal Life Product Section	Kristi Hendrickson	01/22/2013	01/22/2013

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

Disposition

Disposition Date: 01/23/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Confidential Information Authorization		Yes
Form	Confidential Information Authorization for Release of Psychotherapy Notes		Yes
Form	Confidential Information Authorization		Yes
Form	Temporary Conditional Insurance Agreement		Yes
Form (revised)	Tobacco Use Questionnaire		Yes
Form	Tobacco Use Questionnaire	Replaced	Yes
Form (revised)	Application for Reinstatement		Yes
Form	Application for Reinstatement	Replaced	Yes
Form (revised)	Assurity Direct Only Application for Reinstatement		Yes
Form	Assurity Direct Only Application for Reinstatement	Replaced	Yes
Form (revised)	Evidence of Insurability		Yes
Form	Evidence of Insurability	Replaced	Yes
Form	Application for Conversion		Yes
Form (revised)	Life Product Section		Yes

SERFF Tracking #:

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MISC 2012 LIFE

State:

Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Misc 2012 Life

Project Name/Number:

Misc 2012 Life/Misc 2012 Life

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Life Product Section	Replaced	Yes
Form (revised)	Universal Life Product Section		Yes
Form	Universal Life Product Section	Replaced	Yes

SERFF Tracking #:

SEFL-128853240

State Tracking #:

Company Tracking #:

MISC 2012 LIFE

State:

Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Misc 2012 Life

Project Name/Number:

Misc 2012 Life/Misc 2012 Life

Amendment Letter

Submitted Date:

01/22/2013

Comments:

The incorrect forms and form numbers were uploaded in the first submission. The form schedule reflects all correct form numbers.

Changed Items:

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: Misc 2012 Life
 Project Name/Number: Misc 2012 Life/Misc 2012 Life

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	Tobacco Use Questionnaire	47-819-05055 (R08-12)	OTH	Revised	Replaced Form #:75-819-05055 Previous Filing #:SEFL-126646674	53.700	47-819-05055 (R08-12).pdf	Date Submitted: 01/22/2013 By:
<i>Previous Version</i>								
1	Tobacco Use Questionnaire	75-819-05055 (R08-12)	OTH	Revised	Replaced Form #:75-819-05055 Previous Filing #:SEFL-126646674	53.700	75-819-05055 (R08-12).pdf	Date Submitted: 01/18/2013 By: Kristi Hendrickson
2	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>								
2	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
3	Assurity Direct Only Application for Reinstatement	47-852-01052 (R11-12)	AEF	Revised	Replaced Form #:75-852-05055 Previous Filing #:SEFL-126036705	50.000	47-852-01052 (R11-12).pdf	Date Submitted: 01/22/2013 By:
<i>Previous Version</i>								

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: Misc 2012 Life
 Project Name/Number: Misc 2012 Life/Misc 2012 Life

Filing Company: Assurity Life Insurance Company

Form Schedule Item Changes:

Form Schedule Item Changes

3	Assurity Direct Only Application for Reinstatement	75-852- 01052 (R11- 12)	AEF	Revised	Replaced Form #:75- 852-05055 Previous Filing #:SEFL- 126036705	50.000	75-852-01052 (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:

Previous Version

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
5	Life Product Section	47-355- 05051 (R12- 12)	AEF	Revised	Replaced Form #:46- 355-05051 (R05-10) Previous Filing #:SEFL- 126646674	54.600	47-355-05051 (R12- 12).pdf	Date Submitted: 01/22/2013 By:

Previous Version

5	Life Product Section	46-355- 05051 (R12- 12)	AEF	Revised	Replaced Form #:46- 355-05051 (R05-10) Previous Filing #:SEFL- 126646674	54.600	47-355-05051 (R12- 12).pdf	Date Submitted: 01/18/2013 By: Kristi Hendrickson
6	Universal Life Product Section	47-357- 05051 (R09- 12)	AEF	Revised	Replaced Form #:46- 357-05051 (R05-10) Previous Filing #:SEFL- 126646674	52.000	47-357-05051 (R09- 12).pdf	Date Submitted: 01/22/2013 By:

Previous Version

SERFF Tracking #:

SEFL-128853240

State Tracking #:

Company Tracking #:

MISC 2012 LIFE

State:

Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Misc 2012 Life

Project Name/Number:

Misc 2012 Life/Misc 2012 Life

Form Schedule Item Changes:

Form Schedule Item Changes								
6	Universal Life Product Section	46-357-05051 (R09-12)	AEF	Revised	Replaced Form #:46-357-05051 (R05-10) Previous Filing #:SEFL-126646674	52.000	47-357-05051 (R09-12).pdf	Date Submitted: 01/18/2013 By: Kristi Hendrickson

No Rate Schedule Items Changed.

No Supporting Documents Changed.

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: Misc 2012 Life
 Project Name/Number: Misc 2012 Life/Misc 2012 Life

Filing Company: Assurity Life Insurance Company

Form Schedule

Lead Form Number: 75-500-05055 (R11-12)									
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		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		
2		Confidential Information Authorization for Release of Psychotherapy Notes	75-502-05055 (R11-12)	OTH	Initial			50.700	75-502-05055 (R11-12).pdf
3		Confidential Information Authorization	75-504-05055	OTH	Initial			50.100	75-504-05055 (R11-12).pdf
4		Temporary Conditional Insurance Agreement	75-802-05055 (R07-12)	OTH	Revised	Previous Filing Number:	SEFL-126646674	51.400	75-802-05055(R07-12).pdf
						Replaced Form Number:	75-802-05055		
5		Tobacco Use Questionnaire	47-819-05055 (R08-12)	OTH	Revised	Previous Filing Number:	SEFL-126646674	53.700	47-819-05055 (R08-12).pdf
						Replaced Form Number:	75-819-05055		
6		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		

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: Misc 2012 Life
 Project Name/Number: Misc 2012 Life/Misc 2012 Life

Filing Company: Assurity Life Insurance Company

Lead Form Number: 75-500-05055 (R11-12)

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		Assurity Direct Only Application for Reinstatement	47-852-01052 (R11-12)	AEF	Revised	Previous Filing Number:	SEFL-126036705	50.000	47-852-01052 (R11-12).pdf
						Replaced Form Number:	75-852-05055		
8		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		
9		Application for Conversion	75-883-05055	AEF	Other	Replace LC-02 approved 9/13/2002		54.300	75-883-05055.pdf
10		Life Product Section	47-355-05051 (R12-12)	AEF	Revised	Previous Filing Number:	SEFL-126646674	54.600	47-355-05051 (R12-12).pdf
						Replaced Form Number:	46-355-05051 (R05-10)		
11		Universal Life Product Section	47-357-05051 (R09-12)	AEF	Revised	Previous Filing Number:	SEFL-126646674	52.000	47-357-05051 (R09-12).pdf
						Replaced Form Number:	46-357-05051 (R05-10)		

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage

SERFF Tracking #:

SEFL-128853240

State Tracking #:

Company Tracking #:

MISC 2012 LIFE

State: Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: Misc 2012 Life

Project Name/Number: Misc 2012 Life/Misc 2012 Life

PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	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.

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 _____ / _____ <i>Years/Months</i>				
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





PLEASE PRINT WITH BLACK INK

PROPOSED INSURED

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

STATEMENT OF HEALTH

Please complete the following questions for all persons covered under this policy.

- During 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) ____ / ____ / ____
- During the past **5 years**, has any person had any driving violations, including driving while intoxicated, or received or been advised to receive treatment for any drug or alcohol abuse? Yes No
- Has any person **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
- During the past **5 years**, has any person received or been advised to have any test (except HIV tests), treatment, hospitalization, surgery or consultation with a medical professional which has not been completed, or for which results have not been received? ... Yes No
- During the past **5 years**, has any person been diagnosed or treated by a medical professional for heart disease, chronic obstructive pulmonary disease (COPD), cancer, diabetes, stroke, kidney disease or liver disease including hepatitis?..... Yes No
- During the past **5 years**, has any person been: 1) diagnosed or treated for any mental or nervous disorder; 2) admitted to a hospital or psychiatric facility; or 3) received home health care? Yes No
- Please list **any** prescription medications any person covered under this policy has taken in the **past 12 months** and why they were prescribed.

- Enter complete details to questions 2-7 above (if answered YES). If additional space is needed, attach a separate sheet of paper.

PRIMARY CARE PHYSICIAN

Name	Phone No. ()
<i>Street Address</i>	<i>Suite No.</i>
<i>City</i>	<i>State</i>
<i>ZIP+4</i>	
Address	
Date Last Consulted	Reason(s) for Consultation
____ / ____ / ____	Results

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 Signature of Owner (if other than Insured) Signature of Proposed Joint Insured





PLEASE PRINT WITH BLACK INK

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





PLEASE PRINT WITH BLACK INK

1. INSURED

Legal Name	<i>First</i>	<i>Middle</i>	<i>Last</i>	Existing Policy/ Certificate No.
Other Names Previously Used	<i>(i.e., maiden name, nickname, derivative form of first and/or middle name or an alias)</i>			<i>(MM/DD/YYYY)</i>
				Date of Birth / /
Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female		Email	
<i>Street Address</i>		<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Home Address				
Personal Phone No. ()	Birth State/Country		Height ft. in.	Weight lbs.
Has the Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If YES, please list type: _____ amount per day _____ last date of use (MM/DD/YYYY) / /				

2. POLICYOWNER (Complete if Owner is NOT the Insured)

Legal Name	<i>First</i>	<i>Middle</i>	<i>Last</i>	Date of Birth (MM/DD/YYYY) / /
Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female		Email	
<i>Street Address</i>		<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Home Address				
Personal Phone No. ()	Birth State/Country		Relationship to Insured	
Contingent Owner's Name	<i>First</i>	<i>Middle</i>	<i>Last</i>	Contingent Owner's Relationship to Insured

3. BENEFICIARIES (If more space is needed, please attach additional sheets)

Primary Beneficiary Name (First, Middle, Last)	Relationship to Insured	Social Security No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name (First, Middle, Last)	Relationship to Insured	Social Security No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

Trust: Living Trust (Please complete section below.) Testamentary Trust (Will)

Name of Living Trust _____

Date of Trust (MM/DD/YYYY) ____ / ____ / ____ Tax ID No. of Trust _____

Name of Trustee _____

Address of Trustee _____

4. POLICY DESCRIPTION

Evidence of Insurability – Complete the Evidence of Insurability form if: 1) the face amount of the new policy exceeds the amount convertible, 2) the new policy is to include any additional riders that are not on the current policy, 3) any rider on the current policy is not available on a conversion basis without evidence of insurability, or 4) requesting a change to the underwriting class or rate reconsideration.

Plan: Whole Life Face Amount \$ _____

Riders: Disability Waiver of Premium Other _____

If cash value is available, should the Automatic Premium Loan (APL) provision be made effective? Yes No (If no option is selected, APL will apply.)

Non-Forfeiture Option: Extended Term Insurance (ETI) Reduced Paid-up Insurance (RPU) (If no option is selected, ETI will apply.)

Dividend Option: Paid in Cash Paid-up Additions (PUA) Accumulate at Interest Reduce Premium/Cash*
 Reduce Premium/PUA* Reduce Premium/Accumulate at Interest* (If no option is selected, Paid-up Additions (PUA) will apply.)

*Reduce Premium/Cash, Reduce Premium/PUA and Reduce Premium/Accumulate at Interest are **not** available on monthly mode.

Special Instructions or Comments _____

Plan: Universal Life Face Amount \$ _____

Death benefit is face amount unless shown differently here: Face Amount + Accumulated Value

Riders: Disability Waiver of Premium Other _____

Special Instructions or Comments _____

5. PREMIUM PAYMENT MODE

Payor Name	First	Middle	Last	Relationship to Insured
Billing Address	Street Address		City	State ZIP+4

Please indicate preference for payment type and billing frequency below:

Type: Direct billing
 New automatic bank withdrawal — submit signed bank authorization form and, to ensure accuracy, a voided check.
 New automatic credit card withdrawal — submit signed credit card authorization form.]
 Add to existing bank [or credit card] withdrawal Policy No. _____
 Add to existing list bill no. _____ and/or name of company _____

Frequency: Annual Semi-Annual Quarterly Monthly (not available with Direct Billing)

If Universal Life, indicate planned premium amount \$ _____

6. EXISTING POLICY/RIDER HANDLING

Policy — terminate in its entirety Term Rider — terminate in its entirety
 Policy — reduce to \$ _____ Term Rider — reduce to \$ _____

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

Signature of Insured Signature of Owner(s) of Term Policy/Rider being Converted

Signature of Parent/Guardian of Minor Child Signature of Owner(s) of New Policy (If other than Insured)

Signature of Licensed Agent Print Agent Name and Agent No.



LIFE PRODUCT SECTION

1. What is the purpose of this insurance? Personal Key Person Buy/Sell Business Loan Charitable Giving Other _____

2. a. Are there any agreements in place to assign/sell the policy? Yes No

b. Is there any intent to sell the policy after issuance? Yes No

c. Has the insured undergone any life expectancy or health exams in conjunction with a life insurance application or settlement option contract? Yes No

TERM LIFE INSURANCE

Face Amount \$ _____ Number of years for policy: 10-Year 15-Year 20-Year 30-Year

ADDITIONAL BENEFITS AVAILABLE ON TERM LIFE—Check benefit(s) desired and indicate amount requested where applicable.

- | | | | |
|--|----------------------|--|----------------------|
| <input type="checkbox"/> Disability Waiver of Premium Benefit Rider | | <input type="checkbox"/> Other Insured Term Insurance Benefit Rider (<i>complete next page</i>) | \$ _____ |
| <input type="checkbox"/> Monthly Disability Income Rider for Primary Insured | \$ _____ mo. benefit | <input type="checkbox"/> Monthly Disability Income Rider for Other Insured (<i>complete next page</i>) | \$ _____ mo. benefit |
| <input type="checkbox"/> Accident Only Disability Income Rider for Primary Insured | \$ _____ mo. benefit | <input type="checkbox"/> Accident Only Disability Income Rider for Other Insured (<i>complete next page</i>) | \$ _____ mo. benefit |
| <input type="checkbox"/> Critical Illness Benefit Rider for Primary Insured | \$ _____ | <input type="checkbox"/> Critical Illness Benefit Rider- Other Insured (<i>complete next page</i>) | \$ _____ |
| <input type="checkbox"/> Children's Term Insurance Rider (<i>complete next page</i>) | _____ units | <input type="checkbox"/> Return of Premium Benefit Rider | |

WHOLE LIFE INSURANCE

Face Amount \$ _____

If cash value is available, should the Automatic Premium Loan (APL) provision be made effective? (*If no option chosen, APL will apply.*) Yes No

Nonforfeiture Option: (*If no option chosen, ETI will apply*) Extended Term Insurance (ETI) Reduce Paid-Up Insurance (RPU)

Dividend Option: (*If no option chosen, PUA will apply*) Paid-up Additions (PUA) Accumulate at Interest Reduce Premium/PUA
 Reduce Premium/Cash Paid in Cash

ADDITIONAL BENEFITS AVAILABLE ON WHOLE LIFE—Check benefit(s) desired and indicate amount requested where applicable.

- | | | | |
|---|---|--|----------------------|
| <input type="checkbox"/> Disability Waiver of Premium Benefit Rider | | <input type="checkbox"/> Protected Insurability Benefit Rider | \$ _____ |
| <input type="checkbox"/> Monthly Disability Income Rider for Primary Insured | \$ _____ mo. benefit | <input type="checkbox"/> Monthly Disability Income Rider for Other Insured (<i>complete next page</i>) | \$ _____ mo. benefit |
| <input type="checkbox"/> Accident Only Disability Income Rider for Primary Insured | \$ _____ mo. benefit | <input type="checkbox"/> Accident Only Disability Income Rider for Other Insured (<i>complete next page</i>) | \$ _____ mo. benefit |
| <input type="checkbox"/> Critical Illness Benefit Rider for Primary Insured | \$ _____ | <input type="checkbox"/> Critical Illness Benefit Rider- Other Insured (<i>complete next page</i>) | \$ _____ |
| <input type="checkbox"/> Children's Term Insurance Rider (<i>complete next page</i>) | _____ units | <input type="checkbox"/> Accidental Death Benefit Rider | \$ _____ |
| <input type="checkbox"/> Level Term Insurance Benefit Rider for Primary Insured (<i>Select only one</i>): | <input type="checkbox"/> 10-Year <input type="checkbox"/> 20-Year | | \$ _____ |
| <input type="checkbox"/> Level Term Insurance Benefit Rider — Other Insured (<i>Select only one</i>): | <input type="checkbox"/> 10-Year <input type="checkbox"/> 20-Year | | \$ _____ |
| <input type="checkbox"/> Payor Benefit Rider (<i>Complete Health Section for Payor</i>) Payor Name _____ DOB ____/____/____ <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| <input type="checkbox"/> Paid-Up Additions Rider (VER) | <input type="checkbox"/> Periodic Premiums \$ _____ | <input type="checkbox"/> Single Premium | \$ _____ |

SINGLE PREMIUM WHOLE LIFE INSURANCE

Face Amount \$ _____

Dividend Option: (*If no option chosen, PUA will apply*) Paid-Up Additions (PUA) Paid in Cash



UNIVERSAL LIFE PRODUCT SECTION

1. What is the purpose of this insurance? Personal Key Person Buy/Sell Business Loan Charitable Giving Other _____
2. a. Are there any agreements in place to assign/sell the policy? Yes No
- b. Is there any intent to sell the policy after issuance? Yes No
- c. Has the insured undergone any life expectancy or health exams in conjunction with a life insurance application or settlement option contract? Yes No

Plan of Insurance (*check one*): Premier Universal Life Other _____

Face Amount \$ _____ Special Policy Date (*If desired*) _____

Planned periodic premium annualized \$ _____ Amount of Insurance is Face Amount unless shown differently here: Face + Accumulated Value

ADDITIONAL BENEFITS

Check benefit(s) desired and indicate amount requested.

- | | | | |
|--|----------|--|----------|
| <input type="checkbox"/> Disability Waiver | | <input type="checkbox"/> 10-year Additional Insured/Spouse Rider | \$ _____ |
| <input type="checkbox"/> Face Amount Increase Rider | \$ _____ | <input type="checkbox"/> 20-year Additional Insured/Spouse Rider | \$ _____ |
| <input type="checkbox"/> ADB (<i>Accidental Death Benefit</i>) | \$ _____ | <input type="checkbox"/> Children's Term Rider | \$ _____ |
| <input type="checkbox"/> 10-year Term Rider | \$ _____ | <input type="checkbox"/> Other (<i>Please specify</i>) _____ | \$ _____ |
| <input type="checkbox"/> 20-year Term Rider | \$ _____ | <input type="checkbox"/> Other (<i>Please specify</i>) _____ | \$ _____ |

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

Information	Additional Insured	Child Rider No. 1	Child Rider No. 2	Child Rider No. 3
Legal Name <i>(First, Middle, Last)</i>				
Face Amount/Units <i>(Child Rider)</i>	\$ / /	\$ / /	\$ / /	\$ / /
Date of Birth <i>(MM/DD/YYYY)</i>	/ /	/ /	/ /	/ /
Age				
Social Security No.				
Birth State/Country				
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Residing with Proposed 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Proposed Insured				
Employer		Has any proposed insured child:		
Occupation/Duties		a. Ever been diagnosed with or treated for internal cancer or tumor, lymphoma, leukemia, disorder of the lymph nodes or glandular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Gross monthly income	\$ _____	b. Ever been diagnosed with or treated for heart disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If self-employed, net monthly income	\$ _____	c. Had any diagnostic tests recommended but not completed or for which the results are currently unknown or pending? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		If YES to any of the above, please list child(ren)'s name(s): _____		

Has the Additional 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 Additional Insured a United States citizen, or does the Additional Insured have permanent resident (*green card*) status? Yes No

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

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



SERFF Tracking #:

SEFL-128853240

State Tracking #:

Company Tracking #:

MISC 2012 LIFE

State:

Arkansas

Filing Company:

Assurity Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

Misc 2012 Life

Project Name/Number:

Misc 2012 Life/Misc 2012 Life

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Certification-Life.pdf			

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): Life Application Forms 2012

Type of Form: Supplements to Applications

Form No.	Description	Flesch Score
47-355-05051 (R12-12)	Life Product Section	54.6
47-357-05051 (R09-12)	Universal Life Product Section	52.0
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
75-802-05055 (R07-12)	Temporary Conditional Insurance Agreement	51.4
75-819-05055 (R08-12)	Tobacco Use Questionnaire	53.7
75-851-05055 (R11-12)	Application for Reinstatement	50.8
75-852-01052 (R11-12)	Assurity Direct Only Application for Reinstatement	50.0
75-859-05051 (R11-12)	Evidence of Insurability	55.5
75-883-05055	Application for Conversion	54.3


Signature

January 18, 2013

Date

Carol S. Watson
Vice President, General Counsel & Secretary

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: Misc 2012 Life
Project Name/Number: Misc 2012 Life/Misc 2012 Life

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 01/23/2013	Form	Tobacco Use Questionnaire	01/22/2013	75-819-05055 (R08-12).pdf (Superseded)
01/16/2013	Replaced 01/23/2013	Form	Application for Reinstatement	01/22/2013	75-851-05055 (R11-12).pdf (Superseded)
01/16/2013	Replaced 01/23/2013	Form	Assurity Direct Only Application for Reinstatement	01/22/2013	75-852-01052 (R11-12).pdf (Superseded)
01/16/2013	Replaced 01/23/2013	Form	Evidence of Insurability	01/22/2013	75-859-05051 (R11-12).pdf (Superseded)
01/16/2013	Replaced 01/23/2013	Form	Life Product Section	01/22/2013	47-355-05051 (R12-12).pdf
01/16/2013	Replaced 01/23/2013	Form	Universal Life Product Section	01/22/2013	47-357-05051 (R09-12).pdf



PROPOSED 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>
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 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





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				
Owner'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 _____				

STATEMENT OF HEALTH

Please complete the following questions for all persons covered under this policy.

1. During 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) ____ / ____ / ____
2. During the past **5 years**, has any person had any driving violations, including driving while intoxicated, or received or been advised to receive treatment for any drug or alcohol abuse? Yes No
3. Has any person **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. During the past **5 years**, has any person received or been advised to have any test (except HIV tests), treatment, hospitalization, surgery or consultation with a medical professional which has not been completed, or for which results have not been received? ... Yes No
5. During the past **5 years**, has any person been diagnosed or treated by a medical professional for heart disease, chronic obstructive pulmonary disease (COPD), cancer, diabetes, stroke, kidney disease or liver disease including hepatitis?..... Yes No
6. During the past **5 years**, has any person been: 1) diagnosed or treated for any mental or nervous disorder; 2) admitted to a hospital or psychiatric facility; or 3) received home health care? Yes No
7. Please list **any** prescription medications any person covered under this policy has taken in the **past 12 months** and why they were prescribed.

8. Enter complete details to questions 2-7 above (if answered YES). If additional space is needed, attach a separate sheet of paper.

PRIMARY CARE PHYSICIAN

Name			Phone No. ()	
<i>Street Address</i>	<i>Suite No.</i>	<i>City</i>	<i>State</i>	<i>ZIP+4</i>
Address				
Date Last Consulted	Reason(s) for Consultation	Results		
____ / ____ / ____				

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.

____ / ____ / ____ <i>Date (MM/DD/YYYY)</i>	_____ <i>Signature of Proposed Insured</i>	_____ <i>Signature of Owner (if other than Insured)</i>	_____ <i>Signature of Proposed Joint Insured</i>
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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, 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. 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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		/ /			
		/ /			
		/ /			



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

