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

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

- ✓ Use the appropriate application **for the state in which the application is to be signed**.
- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state in which the application is signed.**
- ✓ Use **age last birthday** when preparing illustrations and/or calculating insurance premiums.
- ✓ Obtain all required signatures.
- ✓ Have the proposed insured initial any changes. Corrections with white correction fluid/tape are not acceptable.
- ✓ Comply with all state regulations. Note: NAIC Model Illustration or disclosure statement must accompany this application.
- ✓ Complete all other pertinent and applicable forms padded together in this application.
- ✓ If faxing an application directly to the home office, fax to (877) 864-6630.
- ✓ If mailing directly to the home office, address to:

Assurity Life Insurance Company
Attn: New Business Unit
PO Box 82533
Lincoln NE 68501-2533

To check the **status of an application**, ask **underwriting-related questions** *(including "what if" scenarios)*, **call toll-free** (800) 276-7619, EXT. 4264 **or email** to underwriting@assurity.com.

Stranger-Owned Life Insurance/Investor-Owned Life Insurance *(STOLI/IOLI)*

Assurity Life Insurance Company position on STOLI/IOLI
Assurity Life Insurance Company does not support the use of its life insurance products in situations involving Stranger- or Investor-Owned Life Insurance. The company will take all measures necessary to identify these situations and take appropriate action to disallow these transactions. The company views STOLI/IOLI transactions as an inappropriate use of insurance in violation of its intended purpose. In addition, such use of insurance products may be illegal or in connection with illegal activity based on state laws and regulations.

Definition
Any act, practice or arrangement to initiate or facilitate the issuance of a life insurance policy for the intended benefit of a person who, at the time of the policy origination, does not have an insurable interest in the life of the insured as defined by the company's insurable interest guideline.

Actions
Safeguards and procedures are in place to identify STOLI/IOLI transactions during the underwriting and issue process. Any activities identified as being in violation of our company position will lead to action including, but not limited to, cancellation of the application or policy and termination of the producer/agent contract(s) and appointment with Assurity Life Insurance Company.

Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Application for INDIVIDUAL SINGLE PREMIUM WHOLE LIFE INSURANCE

PROPOSED INSURED

PLEASE PRINT IN BLUE OR BLACK INK

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

Social Security No. | ☐ Male ☐ Female | Email | Age

Home Address (Street Address, City, State, ZIP+4)

Personal Phone No. ( ) | Birth State/Country | Height ft. in. | Weight lbs.

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

If YES, please list type _____ Amount per day _____ Last date of use (MM/DD/YYYY) / /

Has the Proposed Insured ever used any form of marijuana? ..... ☐ Yes ☐ No

If YES, please list last date of use (MM/DD/YYYY) / /

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

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

If not a United States citizen, how long has the Proposed Insured been in the United States? _____

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

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

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

Full-time Employment (Occupation, Duties) | Part-time Employment (Occupation, Duties)

Gross monthly income $ | If self-employed, net monthly income $

POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

If Ownership is a trust, complete the Trust Information section *(page 2)* rather than this section.

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

Social Security No. | Relationship to Insured | Birth State/Country

Home Address (Street Address, City, State, ZIP+4) | Email

Contingent Owner's Name (First, Middle, Last) | Contingent Owner's Relationship to Insured

PRODUCT – SINGLE PREMIUM WHOLE LIFE INSURANCE

Face Amount $ _____ ☐ Single Premium Insurance Rider $ _____

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

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

PREMIUM PAYMENT—Please indicate preference for payment type and billing frequency below

What amount was collected with this application? $ _____

Type

☐ Direct Billing ☐ Automatic Bank Withdrawal

☐ List Billing *(employer)*

Frequency

☐ Annual ☐ Semi-Annual

☐ Quarterly ☐ Monthly *(not available with Direct Billing)*

Payor Name (First, Middle, Last) | Billing Address (Street Address, City, State, ZIP+4)

BENEFICIARY/TRUST INFORMATION

If Beneficiary is a trust, complete the Trust Information section below.

BENEFICIARY INFORMATION

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

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

TRUST INFORMATION

Please complete the following sections if Ownership and/or Beneficiary is a Trust:

1. TRUST POLICYOWNER

Name of Trust

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

Name of Trustee(s)

Tax ID No.

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

2. TRUST BENEFICIARY

☐ Testamentary Trust *(Will)* Share % _____

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

Name of Living Trust

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

Name of Trustee(s)

Tax ID No.

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

GENERAL SECTION

Please answer the following questions. If additional space is needed, attach a separate sheet of paper.

1. Does any Proposed Insured belong to or have they entered into a written agreement to become a member of the military or National Guard? ☐ Yes ☐ No

2. During the past **5 years** or within the next **12 months**:

   a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured intending to fly as a pilot, crew member or student? ☐ Yes ☐ No

   b. Has any Proposed Insured participated in, or intend to participate in, any of the following sports or activities? ☐ Yes ☐ No

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

3. During the next **12 months**, does any Proposed Insured intend to reside or travel outside of the United States? ☐ Yes ☐ No

   If YES, please explain _____

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, amount of weight change and details: diet/better eating, exercise, childbirth, or other:

   _____

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

   a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? ☐ Yes ☐ No

   If YES, please explain _____

   b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ Yes ☐ No

   If YES, please explain _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? ☐ Yes ☐ No

   If YES, please explain _____

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

   a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence *(DUI/DWI)*, or pled guilty or been convicted of any moving violations? ☐ Yes ☐ No

   If YES, please explain _____

   b. Been convicted of a felony? ☐ Yes ☐ No

   If YES, please explain _____

8. Is any Proposed Insured currently on probation? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

   _____

9. Has any Proposed Insured ever filed for bankruptcy? ☐ Yes ☐ No

   If YES, when? _____ Has the bankruptcy been discharged? ☐ Yes ☐ No If YES, when? _____

10. a. Does any Proposed Insured have other annuity or life insurance coverage in force? ☐ Yes ☐ No
    If YES, provide details below.

    b. If this insurance is issued, will it replace, modify or borrow against existing or pending annuity or life insurance coverage? ☐ Yes ☐ No
    If either 10 a or b is answered YES, complete any applicable State Replacement form.

Company Name	Type of Coverage	Amount of Coverage

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

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

HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 5.

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. 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 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, or asthma or other respiratory disorder? ☐ Yes ☐ No

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

   g. Arthritis in any form, fibromyalgia, paralysis or connective tissue disorder *(such as lupus or scleroderma)* 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

2. During the past **10 years**, has any Proposed Insured:

   a. Required a transfusion of whole blood or blood products, including platelets, packed red blood cells or plasma? ☐ 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 diagnosed or treated by a medical professional for acquired immunodeficiency 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

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

   a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? ☐ Yes ☐ No

   b. 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

   c. 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

4. Has any Proposed Insured had a natural parent or sibling who was diagnosed by a medical professional with or died of cancer, heart disease, diabetes, Huntington's disease or polycystic kidney disease prior to the age of 60? ☐ Yes ☐ No

   If YES, please identify family member, relationship to Proposed Insured, disorder and age at death.

   _____

5. a. Has any Proposed Insured **ever** been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No

   b. Is any Proposed Insured currently pregnant? ☐ Yes ☐ No

   If YES, date child is expected *(MM/DD/YYYY)* ____/____/_____

6. Is any Proposed Insured currently taking any prescription medication? ☐ Yes ☐ No

DETAILS: Enter complete details from question numbers 1-6 on page 5. If more space is needed, attach additional Supplemental Information form.

SUPPLEMENTAL HEALTH 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
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			
		/ /			

Additional Information:

PHYSICIAN INFORMATION

Please list the last physician consulted:

Name _____ Date last consulted ____/____/____
MM/DD/YYYY

Address _____
Street Address *Suite*

_____
City *State* *ZIP+4*

Phone No. (____) _____ Fax No. (____) _____

Is this your primary physician? ☐ Yes ☐ No

Reason for consultation _____

Results _____

_____

AGREEMENT

I *(We)* have read the above questions and answers and declare that they are complete and true to the best of my *(our)* knowledge and belief. I *(We)* agree that this application shall form a part of the policy if attached thereto.

I *(We)* agree that:

a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.

b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and the answers on the application remain true, complete and accurate as of the date the first full premium is paid. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.

c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

d. If the Policyowner is someone other than the Insured, in the event of the Policyowner's death (and no Contingent Owner(s) living), the Insured will become the Policyowner.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Substitute Form W-9 information *(Request for Taxpayer Identification Number and Certification)*: I, the Owner *(or each Joint Owner)*, certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person *(including a U.S. resident alien)*. The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

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

_____ _____
Signature of Proposed Insured *Signature of Additional Proposed Insured*

_____ _____
Signature of Parent/Guardian of Minor Child *Signature of Additional Proposed Insured*

_____
Signature of Owner(s) (If other than Proposed Insured)

_____ _____
Signature of Licensed Agent *Print Agent Name and Agent No.*

AGENT STATEMENT

1. a. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ☐ No

   b. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ☐ Yes ☐ No

2. a. Did you personally see each Proposed Insured on the date of application? ☐ Yes ☐ No

   b. How well do you know the Proposed Insured(s)? ☐ Well ☐ Slightly ☐ Not at all

   c. Did the Proposed Insured approach you to purchase insurance? If YES, list their stated need for the insurance_____ ☐ Yes ☐ No

   d. Did the Proposed Insured(s) directly respond to you regarding each application question? ☐ Yes ☐ No

   e. Was a government-issued picture ID requested and reviewed for the Proposed Insured, Owner and Payor? ☐ Yes ☐ No

   f. Was each Proposed Insured present, and did you witness their signatures at the time the application was taken? ☐ Yes ☐ No

   g. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured(s)? If YES, please provide details below. ☐ Yes ☐ No

   _____

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ☐ Yes ☐ No

   Agent is responsible for scheduling exam items.

   NOTE: ANY PREFERRED PLANS REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.

   ☐ Paramedical examination ☐ Blood sample ☐ Urine sample ☐ Electrocardiogram *(EKG)* ☐ Medical exam by physician

4. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

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

6. Was sales material used in soliciting this application? ☐ Yes ☐ No

7. Was the sales material left with the applicant? ☐ Yes ☐ No

8. Was the sales material approved by Assurity Life Insurance Company? ☐ Yes ☐ No

9. Are commissions to be split? ☐ Yes ☐ No Agent Name _____ Agent's No. _____ _____ %

   Agent Name _____ Agent's No. _____ _____ %

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.

☐ Add to existing bank withdrawal—indicate other applicant and/or policy numbers

LIST BILL

☐ Set up NEW list bill—submit signed employer authorization form with the application.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

FOR TERM LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:

☐ Preferred Plus NT ☐ Preferred NT ☐ Standard NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification: _____

FOR WHOLE LIFE APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with application)***

The premiums for this application were quoted on the following underwriting classification:

☐ Preferred Plus NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification: _____

FOR SINGLE PREMIUM WHOLE LIFE APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with application)***

The premiums for this application were quoted on the following underwriting classification:

☐ Standard NT ☐ Standard T ☐ Juvenile

FOR UNIVERSAL LIFE APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with application)***

The premiums for this application were quoted on the following underwriting classification:

☐ Preferred Plus NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification: _____

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____ / / ( ) / ( )

Signature of Soliciting Agent | *Date (MM/DD/YYYY)* | *Business Phone No. and Fax No.*

_____ _____ _____

Soliciting Agent's Printed Name | *Agent No.* | *Agent's E-mail*

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Confidential Information Authorization

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

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

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

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

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

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation)*, occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus *(HIV)* infection and sexually transmitted diseases.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions *(start and stop times)*, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be rediscloseed in accordance with other applicable laws or regulations.

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

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(authorization to disclose HIV-related information is valid for 180 days from the date of the signature below)***, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ / / _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

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

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Confidential Information Authorization

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

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

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

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

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

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation)*, occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus *(HIV)* infection and sexually transmitted diseases.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions *(start and stop times)*, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be rediscloseed in accordance with other applicable laws or regulations.

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

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(authorization to disclose HIV-related information is valid for 180 days from the date of the signature below)***, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ / / _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

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

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Confidential Information Authorization for Release of Psychotherapy Notes

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

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

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

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

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

- Psychotherapy notes

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

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

This authorization is valid for twelve *(12)* months from the date of signature below, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ / / _____ _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

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

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Confidential Information Authorization for Release of Psychotherapy Notes

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

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

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

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

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

- Psychotherapy notes

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted. By this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, MIB Inc., consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health, to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to redisclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

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

This authorization is valid for twelve *(12)* months from the date of signature below, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ / / _____ _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

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

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

CONSUMER NOTICE

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Assurity or its reinsurers may, however, make a brief report thereon to the MIB Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 *(TTY 866-346-3642)*. If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, Assurity will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices, please direct your requests to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended *(15 U.S.C. 1681d)*, notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, Assurity Life Insurance Company *(Assurity)* may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation Assurity requests. Please direct this written request to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Upon receipt of such a request, Assurity will respond by mail within five business days.

Telephone Interview Information

Assurity may require that you complete a confidential telephone interview as a part of your application for insurance. The interview will be conducted by a trained professional and may include *(but is not limited to)* the following topics: occupation, job history, income, personal and business financial information and medical history. All information obtained will be used for underwriting purposes only and will not be released without your written consent.

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Temporary Conditional Insurance Agreement

(for use with Life and Reversionary Annuity products)

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

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

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

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

TERMS AND CONDITIONS

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

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

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

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

MAXIMUM AMOUNT LIMITATION

Assurity's maximum liability under this Agreement shall not exceed the amount of $500,000 if the Proposed Insured(s) is within ages 15 days through 69 years, or $250,000 if the Proposed Insured(s) is within ages 70 through 75, reduced by the face amount of any life insurance and by the present value of any reversionary annuity then in force or pending with Assurity. These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.

REFUND OF PAYMENT

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

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

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

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

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

_____
Signature of Owner (if other than Proposed Insured)

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Temporary Conditional Insurance Agreement

(for use with Life and Reversionary Annuity products)

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

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

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

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

TERMS AND CONDITIONS

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

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

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

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

MAXIMUM AMOUNT LIMITATION

Assurity's maximum liability under this Agreement shall not exceed the amount of $500,000 if the Proposed Insured(s) is within ages 15 days through 69 years, or $250,000 if the Proposed Insured(s) is within ages 70 through 75, reduced by the face amount of any life insurance and by the present value of any reversionary annuity then in force or pending with Assurity. These limits continue until the insurance applied for is issued and delivered during the Proposed Insured's lifetime and continued good health.

REFUND OF PAYMENT

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

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

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

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

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

_____
Signature of Owner (if other than Proposed Insured)

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 888-255-2060

DISCLOSURE STATEMENT

MODIFIED ENDOWMENT CONTRACT

The Technical and Miscellaneous Revenue Act of 1988 created a new type of life insurance contract known as a Modified Endowment Contract *(MEC)*. The 1988 law discourages the use of life insurance as an investment by giving less favorable tax treatment to policies classified as MECs. As indicated later in this disclosure, attempts by the owner to access tax-deferred cash values from a MEC *(directly or indirectly)* before the insured's death are taxed adversely *(compared to a non-MEC policy)*.

Section 7702A of the Internal Revenue Code classifies a policy as a MEC if premiums paid into the policy exceed a certain limit in relation to the policy's death benefit *(including any qualified additional benefits, such as a term rider)*. Premium payments are measured over a timeframe known as the "7-pay test period," and if cumulative premiums during any 7-pay test period exceed the 7-pay limit specified in Section 7702A, the policy is a MEC. A 7-pay test period normally starts on the policy's issue date and ends seven years after the issue date, unless there is a restart of the 7-pay test period due to a material change. Material changes that might generate a restart of the 7-pay test period include a requested increase in the death benefit or an addition of a qualified additional benefit under the contract. Any reduction in a qualified benefit level during any 7-pay test period will generally require the policy's 7-pay limit to be reduced retroactively to the start of that 7-pay test period *(as if this reduced benefit level started when this 7-pay test period began)*. The lower 7-pay limit can cause the policy to become a MEC.

Once a policy becomes a MEC, any amount received or deemed to be received from the policy *(other than a death benefit)* is subject to the following adverse U.S. income tax treatment.

1) An amount distributed directly or indirectly from a MEC, such as cash distributions, withdrawals, loans, assignments, ownership changes or pledges will be considered taxable income until all gain, if any, has been distributed. A distribution made within two years prior to the failure of the 7-pay test will be considered a distribution made in anticipation of such a failure.
2) The taxable income amounts will be subject to a 10 percent penalty tax unless the owner is an individual who has attained age $59\frac{1}{2}$, is disabled, or annuitizes the entire cash value. *(If the owner is a corporation, trust or other entity, such proceeds are subject to the 10 percent penalty tax at any time.)*

This adverse tax treatment is expanded by certain deemed tax treatment rules, which are designed to prevent an owner from avoiding adverse MEC treatment by attempting to gain access to the cash values via alternative methods before death. For instance, all MECs purchased by the same owner during the same calendar year from the same insurer are treated as one MEC. Therefore, any amount received or deemed received from any one of those MECs would be considered taxable income until all gain, if any, has been distributed from all of those MECs combined.

Death benefits from a MEC paid to the beneficiary after the insured's death are still treated as life insurance proceeds and are generally not subject to U.S. income tax.

Assurity does not give tax advice, and this disclosure should not be interpreted as tax advice. Rather, this disclosure is intended to alert you to the potential scope of the adverse U.S. tax treatment of any amounts received or deemed received from a MEC prior to death of the insured. Please consult with a qualified tax advisor if you have questions.

I acknowledge that I have read this disclosure statement and that I understand my plan of insurance with Assurity is a Modified Endowment Contract and therefore subject to special U.S. tax treatment as outlined above.

/ /		
Date (MM/DD/YYYY)	*Signature of Owner/Proposed Owner*	*Printed Name*
Print Insured/Proposed Insured's Name (First, Middle, Last)		*Policy Number (if applicable)*

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

HIV TEST INFORMED CONSENT FORM

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

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health or disability insurance for which you may apply in the future.

HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

The HIV virus causes a life-threatening disorder of the immune system called acquired immune deficiency syndrome *(AIDS)*. Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood *(as in needle sharing during intravenous drug use, or rarely, as a result of a blood transfusion)*, or from an infected mother to her newborn infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

PRE-TESTING CONSIDERATION

Many public health organizations have recommended that before taking an HIV virus antibody test, a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

DISCLOSURE OF TEST RESULTS

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal *(negative)*, you will not be notified. You will be notified of an abnormal *(positive)* test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid *(saliva)* or urine abnormality may be made known to MIB, Inc. *(formerly known as Medical Information Bureau)*. MIB, Inc. is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with MIB, Inc. that you had a positive HIV antibody test; however, there will be a record at MIB, Inc. that you have some blood, oral fluid or urine abnormality. If you apply to another MIB, Inc. member company for life or health insurance coverage, MIB, Inc., upon request, will supply the information on you in its file to that member.

TEST RESULTS

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100 percent accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

OTHER SOURCES OF INFORMATION

For more information about HIV or AIDS, you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS *(2437)*. The hotline is a free call.

CONSENT FOR HIV TESTING

I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood, or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This CONSENT is valid for ninety *(90)* days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this ninety *(90)* day period.

NOTIFICATION OF POSITIVE TEST RESULT

In the event of a positive test result:

☐ Send the result to me at:

_____

Address

☐ I authorize Assurity Life Insurance Company *(Assurity)* to send the result to another person:

_____

Name

_____

Address

☐ I authorize Assurity to send the result to the following physician or health care provider:

_____

Name

_____

Address

AUTHORIZATION

_____

Printed Name of Proposed Insured

_____ _____

Signature of Proposed Insured or Parent/Guardian *Date (MM/DD/YYYY)*

_____ _____

Signature of Person Obtaining Consent *Date (MM/DD/YYYY)*

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Life Insurance or Annuity REPLACEMENT NOTICE

IMPORTANT NOTICE

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by withdrawal, surrender or borrowing of some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs, and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing *(include the name of the insurer, the insured or annuitant, and the policy or contract number if available)* and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name *Date*

_____ _____
Producer's Signature and Printed Name *Date*

Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

I do not want this notice read aloud to me._____ *(Applicant must initial only if they do not want the notice read aloud.)*

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? *(See your tax advisor.)*

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Life Insurance or Annuity REPLACEMENT NOTICE

IMPORTANT NOTICE

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by withdrawal, surrender or borrowing of some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs, and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing *(include the name of the insurer, the insured or annuitant, and the policy or contract number if available)* and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name *Date*

_____ _____
Producer's Signature and Printed Name *Date*

Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

I do not want this notice read aloud to me._____ *(Applicant must initial only if they do not want the notice read aloud.)*

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? *(See your tax advisor.)*

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Illustration Disclosure Statement

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

Name of Agent preparing disclosure _____
First *Middle* *Last*

Proposed Insured's acknowledgement and Agent's certification that:

☐ Application differs from illustration

☐ No illustration used in sales process

☐ Illustrations provided on computer screen. If a computer screen illustration was used, it was based on the following:

Gender: ☐ Male ☐ Female

Age _____

Product Name and Form No. _____

Premium Amount _____

Riders and Form No. _____

Guaranteed Interest Rate _____

Underwriting Class _____

Non-Guaranteed Interest Rate _____

Dividend Option _____

No. of Policy Years Illustrated _____

Initial Death Benefit _____

Assumed No. of Years of Premium _____

PROPOSED INSURED ACKNOWLEDGMENT

I acknowledge that I did not receive an illustration matching my application for insurance for the reason marked above. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

_____ _____
Date (MM/DD/YYYY) *Proposed Insured's Signature*

AGENT CERTIFICATION

I certify that:

a. An illustration matching the application for insurance was not provided at time of sale for the reason marked above.
b. I explained that a conforming illustration would be produced and delivered no later than at the time of policy delivery.
c. I have made no statements that are inconsistent with the illustration that will be produced.

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

Any Proposed Insured residing in MA, ME, PA, SD or WA must retain a copy of this completed form.

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Accelerated Death Benefits Rider DISCLOSURE STATEMENT

ACCELERATED DEATH BENEFITS PAID UNDER THE RIDER WILL REDUCE THE POLICY'S DEATH BENEFIT, PREMIUMS AND POLICY VALUES, WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE CASH VALUE.

THE RIDER IS NOT INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT UNDER SECTION 7702B OF THE INTERNAL REVENUE CODE.

RECEIPT OF BENEFITS PAID UNDER THE RIDER ARE INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT UNDER SECTION 101(g) OF THE FEDERAL INTERNAL REVENUE CODE. HOWEVER, DEPENDING ON INDIVIDUAL CIRCUMSTANCES OR CHANGES TO THAT CODE, PAYMENT MADE UNDER THE RIDER MAY BE TAXABLE. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS BEFORE REQUESTING ANY ACCELERATED DEATH BENEFIT.

IN ADDITION, RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID, SUPPLEMENTAL SOCIAL SECURITY INCOME, OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. YOU SHOULD CONSULT EACH APPLICABLE GOVERNMENT AGENCY BEFORE RECEIVING AN ACCELERATED DEATH BENEFIT TO ASSESS THE IMPACT ON ELIGIBILITY OF SUCH ASSISTANCE.

The rider is attached to and part of the policy. The terms of the policy apply to the rider unless otherwise stated in the rider. The rider is issued in return for Your approved Application.

DEFINITIONS

Accelerated Amount means the portion of the Eligible Proceeds You elect to accelerate.

Acceleration Factor means the Accelerated Amount divided by the Eligible Proceeds.

Activities of Daily Living means certain basic daily tasks necessary to maintain the Insured Person's health and safety. Activities of Daily Living refer to the activities described below:

- ***Bathing*** means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
- ***Continence*** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- ***Dressing*** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- ***Eating*** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table), feeding tube or intravenously.
- ***Toileting*** means getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.
- ***Transfer and Mobility*** means the ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, wheelchair, cane, crutches, walker or other equipment.

Benefit Amount means the Accelerated Amount adjusted by the Discount Factor less the Processing Charge.

Chronic Illness means an illness or physical condition in which the Insured Person has been certified by a Physician as

- being unable to perform at least two Activities of Daily Living, without Substantial Assistance from another person, due to a loss of functional capacity for a period of at least the last 90 consecutive days; or
- requiring Substantial Supervision by another person to protect the Insured Person from threats to health and safety due to the Insured Person's Severe Cognitive Impairment for a period of at least the last 90 consecutive days.

Discount Factor means a factor that is applied to the Accelerated Amount, which accounts for

- the future expected lifetime of the Insured Person;
- the Insured Person's Age and duration, Class and Gender (unless this policy was issued on a gender-neutral basis, in which case male rates will be assumed);
- the future premiums;
- the current Dividends, if any; and
- an interest rate. The maximum interest rate used will be no more than the greater of a) the current yield on 90-day treasury bills or b) the current maximum adjustable policy loan interest rate allowed by law.

Eligible Proceeds means the policy Face Amount in force plus any Paid-Up Additions. Eligible Proceeds does not include insurance coverage that is still subject to the policy's Contestable Period or Suicide provisions.

Immediate Family means a spouse, father, mother, children or siblings.

Net Rider Benefit Amount means the Benefit Amount less the pro rata loan repayment, if any.

Physician means a doctor of medicine or osteopathy who is duly licensed by the state medical board and practicing in the United States. Such Physician cannot be a member of Your or an Insured Person's Immediate Family or business associate and must be providing services within the scope of his or her license/specialty. Physician will also include nurse practitioners and physician assistants. Practitioners other than those named above are not Physicians.

Processing Charge means the administrative charge assessed when benefits are accelerated under this rider. The Processing Charge will not exceed $500. We will inform You of the charge when You request this rider's benefit.

Severe Cognitive Impairment means the deterioration or loss of intellectual capacity that:

- places the Insured Person in jeopardy of harming himself or herself or others and requires Substantial Supervision from another individual; and
- is measured by clinical evidence and standardized tests which reliably measure impairment in short-term or long-term memory; orientation to people, places, or time; deductive or abstract reasoning; or judgement as it relates to safety awareness.

Substantial Assistance means hands-on or stand-by assistance. Hands-on assistance means the physical assistance of another person without which the Insured Person would be unable to perform an Activity of Daily Living. Stand-by assistance means the presence of another person within arm's reach of the Insured Person that is necessary to prevent, by physical intervention, injury to the Insured Person while the Insured Person is performing an Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gesture or other demonstrations) by another person that is necessary to protect the Insured Person from threats to his or her health or safety.

Terminal Illness means a condition that results in an expected life span of 12 months or less. Such a condition must be certified by a Physician.

BENEFITS

Payment of Accelerated Benefits. If an Insured Person qualifies for the Terminal Illness Option or the Chronic Illness Option, We will pay You the Net Rider Benefit Amount. The Net Rider Benefit Amount will be paid to You or Your estate unless You have otherwise assigned or designated benefits.

If the Insured Person dies after You elect to receive the Net Rider Benefit Amount, but before any such benefits are received, the election shall be cancelled and the death benefit paid pursuant to the policy.

Terminal Illness Option. This option allows You to receive the Net Rider Benefit Amount as a lump sum if an Insured Person is diagnosed with a Terminal Illness. The Benefit Amount will never be less than the Acceleration Factor multiplied by the Surrender Value of the policy to which this rider is attached. If You do not want to receive the payment in a lump sum, You can elect to be paid in 12 equal monthly payments. If You take 12 payments, We will pay interest of not less than 1% per year. If the Insured Person dies before all 12 payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payments.

The Accelerated Amount for Terminal Illness must be an amount such that the policy's remaining Face Amount after the Net Rider Benefit Amount is paid is at least equal to $10,000.

Chronic Illness Option. This option is only available for under age 76 at issue. This option allows You to receive the Net Rider Benefit Amount as a lump sum if an Insured Person is diagnosed with a Chronic Illness. The Benefit Amount will never be less than the Acceleration Factor multiplied by the Surrender Value of the policy to which this rider is attached. You may request acceleration for Chronic Illness annually. We may require certification by a Physician each year that the Insured Person has a Chronic Illness and requests acceleration.

The maximum Benefit Amount in any 12 month period is the annualized per diem limitation declared by the Internal Revenue Service (IRS) for the calendar year in which this rider is exercised.

The Accelerated Amount for Chronic Illness must be an amount such that the policy's remaining Face Amount after the Net Rider Benefit Amount is paid is at least equal to $10,000.

REQUIREMENTS

Conditions. Accelerated benefits under the rider are subject to the following conditions:

- Eligible Proceeds does not include insurance coverage that is still subject to the policy's Contestable Period or Suicide provisions.
- You must provide a written certification from a Physician that the Insured Person has been diagnosed with a Chronic Illness or Terminal Illness.
- We have the right to have the Insured Person examined by a Physician We choose, at Our expense, in order to obtain a second medical opinion. If the second medical opinion does not confirm the diagnosis and eligibility for payment, then a third opinion, at Our expense by a Physician that is mutually acceptable to You and Us will determine eligibility for the payment of acceleration of benefits.
- You can request an Accelerated Amount no more frequently than once every 12 months.
- Any amount required to keep the policy from terminating must be paid before the Net Rider Benefit Amount will be paid.
- If your policy is assigned or has an irrevocable Beneficiary, a signed acknowledgement form must be submitted to Our administrative office before We will pay the Net Rider Benefit Amount.
- The sum of all Accelerated Amounts may not exceed $250,000.

Upon request to accelerate the benefits, We will provide You and any irrevocable Beneficiary a statement demonstrating the effect of acceleration of benefits on Your policy's death benefit, premiums and policy values. This information will be provided to You and any irrevocable Beneficiary again upon payment of the Net Rider Benefit Amount.

General Requirements. You cannot elect to receive the Net Rider Benefit Amount:

- if Your policy is on extended term insurance; or
- if You are required by law or government to use this rider to pay creditors' claims, whether in bankruptcy or otherwise; or to apply for, obtain, or keep a government benefit or entitlement.

EFFECT ON POLICY

Following the payment of the Net Rider Benefit Amount, the policy will stay in force at a reduced amount. The Face Amount, paid-up additional insurance, cash value and loan balance, will be reduced on a pro rata basis, based upon the applicable Acceleration Factor. The reduction to the loan balance will be considered a loan repayment. Upon acceleration, premiums due and dividends credited will be adjusted based on the reduced amount

GENERAL PROVISIONS

Contestable Period. The rider is contestable on the same basis as the policy to which it is attached.

Reinstatement. If the policy is reinstated, the rider will be reinstated unless any Benefit Amount has been paid under the rider.

Termination. The rider will terminate on the earlier of the following dates:

- the date the policy terminates for any reason;
- the date We receive Your written notice at Our administrative office to terminate the rider unless the notice specifies a later date;
- the date the policy becomes extended term insurance coverage under the nonforfeiture option;
- the date the sum of all Accelerated Amounts equals $250,000; or
- the rider's Expiration Date listed on the policy Schedule.

If Your policy is assigned or has an irrevocable Beneficiary, a signed acknowledgement form must be submitted to Our administrative office.

Signature of Proposed Insured	*Printed Name of Proposed Insured*	/ / *Date (MM/DD/YYYY)*
Signature of Agent	*Printed Name of Agent*	/ / *Date (MM/DD/YYYY)*

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Accelerated Death Benefits Rider DISCLOSURE STATEMENT

ACCELERATED DEATH BENEFITS PAID UNDER THE RIDER WILL REDUCE THE POLICY'S DEATH BENEFIT, PREMIUMS AND POLICY VALUES, WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE CASH VALUE.

THE RIDER IS NOT INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT UNDER SECTION 7702B OF THE INTERNAL REVENUE CODE.

RECEIPT OF BENEFITS PAID UNDER THE RIDER ARE INTENDED TO QUALIFY FOR FAVORABLE TAX TREATMENT UNDER SECTION 101(g) OF THE FEDERAL INTERNAL REVENUE CODE. HOWEVER, DEPENDING ON INDIVIDUAL CIRCUMSTANCES OR CHANGES TO THAT CODE, PAYMENT MADE UNDER THE RIDER MAY BE TAXABLE. YOU SHOULD CONSULT YOUR TAX ADVISOR TO DISCUSS THIS BEFORE REQUESTING ANY ACCELERATED DEATH BENEFIT.

IN ADDITION, RECEIPT OF ACCELERATED DEATH BENEFITS MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID, SUPPLEMENTAL SOCIAL SECURITY INCOME, OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. YOU SHOULD CONSULT EACH APPLICABLE GOVERNMENT AGENCY BEFORE RECEIVING AN ACCELERATED DEATH BENEFIT TO ASSESS THE IMPACT ON ELIGIBILITY OF SUCH ASSISTANCE.

The rider is attached to and part of the policy. The terms of the policy apply to the rider unless otherwise stated in the rider. The rider is issued in return for Your approved Application.

DEFINITIONS

Accelerated Amount means the portion of the Eligible Proceeds You elect to accelerate.

Acceleration Factor means the Accelerated Amount divided by the Eligible Proceeds.

Activities of Daily Living means certain basic daily tasks necessary to maintain the Insured Person's health and safety. Activities of Daily Living refer to the activities described below:

- ***Bathing*** means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
- ***Continence*** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- ***Dressing*** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- ***Eating*** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table), feeding tube or intravenously.
- ***Toileting*** means getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene.
- ***Transfer and Mobility*** means the ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, wheelchair, cane, crutches, walker or other equipment.

Benefit Amount means the Accelerated Amount adjusted by the Discount Factor less the Processing Charge.

Chronic Illness means an illness or physical condition in which the Insured Person has been certified by a Physician as

- being unable to perform at least two Activities of Daily Living, without Substantial Assistance from another person, due to a loss of functional capacity for a period of at least the last 90 consecutive days; or
- requiring Substantial Supervision by another person to protect the Insured Person from threats to health and safety due to the Insured Person's Severe Cognitive Impairment for a period of at least the last 90 consecutive days.

Discount Factor means a factor that is applied to the Accelerated Amount, which accounts for

- the future expected lifetime of the Insured Person;
- the Insured Person's Age and duration, Class and Gender (unless this policy was issued on a gender-neutral basis, in which case male rates will be assumed);
- the future premiums;
- the current Dividends, if any; and
- an interest rate. The maximum interest rate used will be no more than the greater of a) the current yield on 90-day treasury bills or b) the current maximum adjustable policy loan interest rate allowed by law.

Eligible Proceeds means the policy Face Amount in force plus any Paid-Up Additions. Eligible Proceeds does not include insurance coverage that is still subject to the policy's Contestable Period or Suicide provisions.

Immediate Family means a spouse, father, mother, children or siblings.

Net Rider Benefit Amount means the Benefit Amount less the pro rata loan repayment, if any.

Physician means a doctor of medicine or osteopathy who is duly licensed by the state medical board and practicing in the United States. Such Physician cannot be a member of Your or an Insured Person's Immediate Family or business associate and must be providing services within the scope of his or her license/specialty. Physician will also include nurse practitioners and physician assistants. Practitioners other than those named above are not Physicians.

Processing Charge means the administrative charge assessed when benefits are accelerated under this rider. The Processing Charge will not exceed $500. We will inform You of the charge when You request this rider's benefit.

Severe Cognitive Impairment means the deterioration or loss of intellectual capacity that:

- places the Insured Person in jeopardy of harming himself or herself or others and requires Substantial Supervision from another individual; and
- is measured by clinical evidence and standardized tests which reliably measure impairment in short-term or long-term memory; orientation to people, places, or time; deductive or abstract reasoning; or judgement as it relates to safety awareness.

Substantial Assistance means hands-on or stand-by assistance. Hands-on assistance means the physical assistance of another person without which the Insured Person would be unable to perform an Activity of Daily Living. Stand-by assistance means the presence of another person within arm's reach of the Insured Person that is necessary to prevent, by physical intervention, injury to the Insured Person while the Insured Person is performing an Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gesture or other demonstrations) by another person that is necessary to protect the Insured Person from threats to his or her health or safety.

Terminal Illness means a condition that results in an expected life span of 12 months or less. Such a condition must be certified by a Physician.

BENEFITS

Payment of Accelerated Benefits. If an Insured Person qualifies for the Terminal Illness Option or the Chronic Illness Option, We will pay You the Net Rider Benefit Amount. The Net Rider Benefit Amount will be paid to You or Your estate unless You have otherwise assigned or designated benefits.

If the Insured Person dies after You elect to receive the Net Rider Benefit Amount, but before any such benefits are received, the election shall be cancelled and the death benefit paid pursuant to the policy.

Terminal Illness Option. This option allows You to receive the Net Rider Benefit Amount as a lump sum if an Insured Person is diagnosed with a Terminal Illness. The Benefit Amount will never be less than the Acceleration Factor multiplied by the Surrender Value of the policy to which this rider is attached. If You do not want to receive the payment in a lump sum, You can elect to be paid in 12 equal monthly payments. If You take 12 payments, We will pay interest of not less than 1% per year. If the Insured Person dies before all 12 payments are made, We will pay You or Your estate the present value of future payments based on the interest rate used to calculate the original payments.

The Accelerated Amount for Terminal Illness must be an amount such that the policy's remaining Face Amount after the Net Rider Benefit Amount is paid is at least equal to $10,000.

Chronic Illness Option. This option is only available for under age 76 at issue. This option allows You to receive the Net Rider Benefit Amount as a lump sum if an Insured Person is diagnosed with a Chronic Illness. The Benefit Amount will never be less than the Acceleration Factor multiplied by the Surrender Value of the policy to which this rider is attached. You may request acceleration for Chronic Illness annually. We may require certification by a Physician each year that the Insured Person has a Chronic Illness and requests acceleration.

The maximum Benefit Amount in any 12 month period is the annualized per diem limitation declared by the Internal Revenue Service (IRS) for the calendar year in which this rider is exercised.

The Accelerated Amount for Chronic Illness must be an amount such that the policy's remaining Face Amount after the Net Rider Benefit Amount is paid is at least equal to $10,000.

REQUIREMENTS

Conditions. Accelerated benefits under the rider are subject to the following conditions:

- Eligible Proceeds does not include insurance coverage that is still subject to the policy's Contestable Period or Suicide provisions.
- You must provide a written certification from a Physician that the Insured Person has been diagnosed with a Chronic Illness or Terminal Illness.
- We have the right to have the Insured Person examined by a Physician We choose, at Our expense, in order to obtain a second medical opinion. If the second medical opinion does not confirm the diagnosis and eligibility for payment, then a third opinion, at Our expense by a Physician that is mutually acceptable to You and Us will determine eligibility for the payment of acceleration of benefits.
- You can request an Accelerated Amount no more frequently than once every 12 months.
- Any amount required to keep the policy from terminating must be paid before the Net Rider Benefit Amount will be paid.
- If your policy is assigned or has an irrevocable Beneficiary, a signed acknowledgement form must be submitted to Our administrative office before We will pay the Net Rider Benefit Amount.
- The sum of all Accelerated Amounts may not exceed $250,000.

Upon request to accelerate the benefits, We will provide You and any irrevocable Beneficiary a statement demonstrating the effect of acceleration of benefits on Your policy's death benefit, premiums and policy values. This information will be provided to You and any irrevocable Beneficiary again upon payment of the Net Rider Benefit Amount.

General Requirements. You cannot elect to receive the Net Rider Benefit Amount:

- if Your policy is on extended term insurance; or
- if You are required by law or government to use this rider to pay creditors' claims, whether in bankruptcy or otherwise; or to apply for, obtain, or keep a government benefit or entitlement.

EFFECT ON POLICY

Following the payment of the Net Rider Benefit Amount, the policy will stay in force at a reduced amount. The Face Amount, paid-up additional insurance, cash value and loan balance, will be reduced on a pro rata basis, based upon the applicable Acceleration Factor. The reduction to the loan balance will be considered a loan repayment. Upon acceleration, premiums due and dividends credited will be adjusted based on the reduced amount

GENERAL PROVISIONS

Contestable Period. The rider is contestable on the same basis as the policy to which it is attached.

Reinstatement. If the policy is reinstated, the rider will be reinstated unless any Benefit Amount has been paid under the rider.

Termination. The rider will terminate on the earlier of the following dates:

- the date the policy terminates for any reason;
- the date We receive Your written notice at Our administrative office to terminate the rider unless the notice specifies a later date;
- the date the policy becomes extended term insurance coverage under the nonforfeiture option;
- the date the sum of all Accelerated Amounts equals $250,000; or
- the rider's Expiration Date listed on the policy Schedule.

If Your policy is assigned or has an irrevocable Beneficiary, a signed acknowledgement form must be submitted to Our administrative office.

Signature of Proposed Insured	*Printed Name of Proposed Insured*	/ / *Date (MM/DD/YYYY)*
Signature of Agent	*Printed Name of Agent*	/ / *Date (MM/DD/YYYY)*

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Customer Identification INFORMATION

PLEASE PRINT WITH BLACK INK

ANTI-MONEY LAUNDERING PROGRAM REQUIRES THE AGENT TO COMPLETE THIS FORM, PROVIDING THE FOLLOWING INFORMATION:

Legal name of Policyowner _____ **Social Security number** _____

Policyowner's occupation _____

1. Source of funds

- ☐ Current income
- ☐ 401k/Pension
- ☐ CD/Savings/Checking
- ☐ Mutual funds/Stocks
- ☐ Another person *(if so, provide name and relationship below)*

_____

- ☐ Inheritance
- ☐ Proceeds of canceled life insurance policy
- ☐ Annuity
- ☐ From values of existing life insurance policy
- ☐ Death benefit proceeds
- ☐ Other _____

2. Is the source of funds a variable life insurance or annuity contract? ☐ Yes ☐ No

If YES, are you licensed to sell variable contracts? ☐ Yes ☐ No

3. Intended purpose of coverage applied for

- ☐ Burial/final expenses
- ☐ Retirement
- ☐ Mortgage pay-off
- ☐ Funding a charitable contribution
- ☐ Periodic income
- ☐ Post-death family needs
- ☐ Educational expenses
- ☐ Business need *(e.g. key-person life insurance)*
- ☐ Other _____

4. Is this application the result of a lead? ☐ Yes ☐ No

If NO, please provide the information below in questions 5 and 6. If YES, proceed to question number 7.

5. Agent/Policyowner relationship

Length of time known *(in years)* _____ How known? _____

6. Provide any additional information you possess regarding the background of your relationship with the Policyowner

_____

_____

7. The information on this form was obtained from

Name _____

☐ Policyowner ☐ Applicant ☐ Payor ☐ Other *(specify)* _____

I certify all of the above information is true and correct to the extent of my knowledge and reflects the information provided to me by the individual named above, except where information from me is required.

_____ _____
Producer Signature *Producer No.*

_____ / /
Producer Name (printed) *Date (MM/DD/YYYY)*

Mail or fax *(877-864-6630)* this completed and signed form along with the application submitted to the home office.

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Life Insurance or Annuity REPLACEMENT NOTICE

IMPORTANT NOTICE

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by withdrawal, surrender or borrowing of some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs, and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing *(include the name of the insurer, the insured or annuitant, and the policy or contract number if available)* and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

_____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name *Date*

_____ _____
Producer's Signature and Printed Name *Date*

Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

I do not want this notice read aloud to me._____ *(Applicant must initial only if they do not want the notice read aloud.)*

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? *(See your tax advisor.)*

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

Assurity®Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-869-0355 | FAX 877-864-6630

Life/Annuity
TRANSFER/1035 EXCHANGE FORM

A. INSTRUCTIONS

1. Owner's signature and date of completion are required on this form.
2. For transfers or 1035 exchanges from annuities or life products, a replacement form must be completed if required by state.
3. Use a separate form for each company. Please print in black ink.

B. COMPANY INFORMATION

_____ ( ) _____
Current Trustee/Custodian/Insurance Company *Telephone No.*

_____ _____ _____ _____
Company Address *City* *State* *ZIP+4*

_____ _____
Contract/Policy/Account No. *Investment Vehicle (CD, Mutual Fund, Life Insurance, Annuity)*

_____ _____ _____ _____
Insured/Annuitant's Full Name *Social Sec. or Tax I.D. No.* *Joint Insured/Annuitant's Full Name* *Social Sec. or Tax I.D. No.*

_____ _____ _____ _____
Policyowner/Account Owner's Full Name (if different from Insured or Annuitant) *Social Sec. or Tax I.D. No.* *Joint Owner's Full Name (if applicable)* *Social Sec. or Tax I.D. No.*

C. POLICY INFORMATION

The contract is: ☐ ENCLOSED ☐ NOT ENCLOSED *(partial exchange only)*

☐ LOST/DESTROYED—I certify that the policy is lost or destroyed. I also certify that the policy has not been assigned or pledged as collateral.

D. TYPE OF TRANSACTION

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS

☐ 1. **1035 EXCHANGE** from a nonqualified annuity or life insurance policy(ies) *(including IRS Section 457 Deferred Compensation)*.

A surrender of a life insurance policy to a non-qualified annuity, or a non-qualified annuity to another non-qualified annuity, qualifies as a 1035 exchange. A surrender of any type of annuity to a life insurance policy does NOT qualify as a 1035 exchange—any gain on your existing annuity will be subject to income tax. Exchanges into existing contracts should be approached cautiously, and only after consultation with a tax advisor, since the IRS has not yet issued definitive guidance regarding the permissibility of such exchanges.

I hereby make a partial or absolute assignment *(endorsement for contracts that are not assignable)* and understand that an absolute assignment transfers all rights, title and interest of every nature and character in and to the above policy to the insurance company indicated above in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. I represent that the above policy is not subject to any pledge, assignment, levy or legal proceeding. Upon receipt, the insurance company is directed to surrender all or part of the policy and apply the value to an annuity or life insurance policy for which I have submitted an application.

I understand that by executing this assignment, I irrevocably waive all rights, claims and demands under the above policy. I am aware of all penalties which may apply.

I acknowledge that the insurer is furnishing this form and participating in this transaction as an accommodation to me, and the indicated insurer assumes no responsibility or liability for my tax treatment under Section 1035 of the Internal Revenue Code or otherwise.

NOTICE REGARDING PARTIAL 1035 EXCHANGES TO EXISTING CONTRACTS: Partial exchanges with subsequent withdrawals or annuitizations may be subject to IRS challenge if entered into for the purpose of avoiding premature withdrawal or other penalties. In addition, the Internal Revenue Service has not issued guidelines regarding the apportionment of basis between contracts involved in partial exchanges. Until such guidance is issued, Assurity will utilize a pro-rata formula for such apportionment. While Assurity believes this will be consistent with any IRS guidelines ultimately issued, these guidelines could mandate a different allocation method.

☐ COMPLETE—Surrender/Liquidate all assets in my account totaling $ _____

☐ PARTIAL—Surrender/Liquidate assets totaling $ _____

Send the proceeds to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533:

☐ IMMEDIATELY—I am aware of all penalties which may apply.

☐ UPON MATURITY—Maturity date ____/____/_____ *(MM/DD/YYYY)*

Is this a 1035 exchange to an existing account? ☐ YES ☐ NO **If YES, provide policy no.** _____

D. TYPE OF TRANSACTION *(continued)*

☐ 2. **TRANSFER QUALIFIED RETIREMENT ACCOUNT(S) (CURRENT PLAN TYPE)**

☐ ROTH IRA ☐ Simple IRA ☐ Traditional IRA ☐ SEP IRA
☐ KEOGH ☐ 401*(k)* ☐ Qualified Retirement Plan

☐ COMPLETE—Surrender/Liquidate all assets in my account totaling $ _____

☐ PARTIAL—Surrender/Liquidate assets totaling $ _____

Send the proceeds to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533:

☐ IMMEDIATELY—I am aware of all penalties which may apply.

☐ UPON MATURITY—Maturity date ____/____/_____ *(MM/DD/YYYY)*

Is this a transfer to an existing account? ☐ YES ☐ NO **If YES, provide policy no.** _____

E. SIGNATURES

Under penalty of perjury, I certify that the foregoing information is true, correct and complete.

____/____/_____	_____	_____
Date (MM/DD/YYYY)	*Signature of Contract Owner*	*Printed Name*
____/____/_____	_____	_____
Date (MM/DD/YYYY)	*Signature of Joint Owner (if applicable)*	*Printed Name*

SIGNATURE GUARANTEE *(if required by the prior carrier)*	**ASSURITY LIFE INSURANCE COMPANY** By _____ Title _____