

Assurity Life Insurance Company

Application # _____



APPLICATION FOR INSURANCE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

www.assurity.com
1-866-289-7337
P.O. Box 80926
Lincoln, Nebraska
68501-0926

Application must be completed and signed in black ink.

PART A - THIS SECTION MUST ALWAYS BE COMPLETED.

1. Proposed Insured (Employee)

Male Female _____
(Last) (First) (MI)

Address _____

City _____ ST _____ Zip _____ Home Phone # (____) _____ - _____

Base Monthly Salary _____ Occupation/Job Description _____

Employer _____ Dept# _____ Hire Date ____/____/____ Birth Date ____/____/____ Issue Age _____
Mo/Day/Yr Mo/Day/Yr

Social Security Number _____ - _____ - _____

Have you used ANY form of Tobacco within the last twelve- (12) months? Yes No

Beneficiary (full name and relationship) _____
Primary Contingent

Owner, if other than Proposed Insured (Employee) _____
Name Relationship Address if other than above

Dependent's Insurance: (NOTE: The beneficiary of dependent's insurance is in all cases the Proposed Insured (Employee))

Name: (First-MI-Last)	Date of Birth (Mo/Day/Yr)	Issue Age	Relationship To Proposed Insured (Employee)
_____	_____	_____	(Spouse)
_____	_____	_____	(Child)
_____	_____	_____	(Child)
_____	_____	_____	(Child)
_____	_____	_____	(Child)

2. Have any persons to be insured consulted a Physician, received medical treatment of any kind, been disabled or hospitalized in the past three years? (If Yes, complete # 7) Yes No

3. Have any persons to be insured ever been medically diagnosed or treated as having "AIDS" (Acquired Immune Deficiency Syndrome), AIDS Related Complex (ARC), or Antibodies to Human T-lymphotrophic Virus Type III (HTLV) prior to today? Yes No

4. During the past six months, has the Proposed Insured (Employee) been limited in performing normal activity in a job for 30 hours or more per week? Yes No

5. **For Cancer and Specified Disease Applicants ONLY:** All Persons to be insured are not now nor ever have been treated nor diagnosed for cancer or any malignancy or the following diseases: Addison's Disease, Botulism, Brucellosis, Budd-Chiari Syndrome, Cystic Fibrosis, Diphtheria, Encephalitis, Histoplasmosis, Legionnaire's Disease, Lou Gehrig's Disease, Lupus Erythematosus, Malaria, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Osteomyelitis, Polio, Q Fever, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Shock Syndrome, Trichinosis, Tuberculosis, Typhoid Fever, Whooping Cough except [enter name(s)] (if none, state "NONE"). _____ The person named above will be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant before policy issuance.

6. **For Hospital Intensive Care Rider Applicants ONLY:** All Persons to be insured are not now nor ever have been diagnosed nor treated as a victim of a heart attack, heart condition, heart trouble, nor any abnormality of the heart, prior to this date except [enter name(s)] who is/are to be excluded (if none, state "NONE") _____ from coverage for any intensive care confinement resulting from any disorder of the heart, and shall be limited to three days coverage in connection with any other intensive care confinement. The person named above will be excluded in part or in total from coverage by an Elimination Rider to be signed by the applicant before policy issuance.

7. Explanation for #2. Give details including name, dates, diagnosis, outcome, name and dosage of medications taken and Physician's Address/Phone. Use additional sheets of paper if necessary. The Proposed Insured (Employee) must sign each additional sheet and the agent must sign as witness.

Person to be Insured (First-MI-Last)	Relationship to Proposed Insured (Employee)	Question #	Explanation	Physician/Address/Phone #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

8. Has the Proposed Insured (Employee), if eligible for or covered by Medicare, received a copy of:

a) the "Guide to Health Insurance for People with Medicare"? Yes No

b) the "Medicare Duplication Acknowledgement Form"? Yes No

9. INSURED'S STATEMENT: Will the policy applied for replace or change any insurance or annuities in force on the life of any person to be insured? (If Yes, give name of company, policy number being replaced/ changed and enclose any required state replacement forms.) Yes No

10. AGENT'S STATEMENT: Does this insurance replace or change any existing insurance or annuities? Yes No
If YES, and if required, is replacement form completed and attached?
If NO, give details _____

All Applicants

I have read the answers and statements written in this application, and represent each and all of them to be true and complete to the best of my knowledge and belief. In the absence of fraud, my answers in this application shall be deemed representations and not warranties. I agree that a copy of this application and any supplement shall be attached to and form a part of any policy issued. Acceptance of any insurance policy issued on this application will constitute a ratification of any corrections or additions to the application noted by the Company in the space headed "HOME OFFICE CORRECTIONS OR ADDITIONS" for administrative purposes. A photostatic copy of the amended application attached to the policy will be sufficient notice of such corrections or additions.

The insurance applied for shall be in force as of the date of the Proposed Effective Date, provided that the Company approves the application without any modification as to the plan, amount or premium, and, further provided that the Company receives the first premium payment from my employer within 90 days from the date of the payroll deduction authorization signed by me. If the first premium is not received within 90 days, no insurance will become effective. If the application is approved with any such modification, the insurance shall not take effect until the policy has been delivered to and accepted by me and shall not take effect if there has been a change in the health of any person to be insured as stated since the date of the application.

I certify that I have received the Outline of Coverage.

The employee will be the owner unless otherwise stated.

Applicants of PART B

I acknowledge receipt of the notice regarding the Medical Information Bureau and consumer reports detached from this application. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, or that of my family members, to give to Assurity Life Insurance Company or its reinsurers any such information. This authorization extends to and includes information or records pertaining to psychiatric, drug or alcohol use history. I authorize Assurity Life Insurance Company to obtain an investigative consumer report on my spouse or me. **A photocopy or an electronic similarity of this authorization shall be as valid as the original. AS AN EMPLOYEE, working a minimum of at least 30 hours per week for this employer, I agree that I have selected the products indicated above, and understand the total monthly premium will be deducted from my paycheck.**

Home Office corrections and additions only			
Proposed Effective Date: _____		Group Number: _____	
Signed at (city & state)	Date	Signature of Proposed Insured (Employee)	
(____)Percentage	Licensed Agent	Signature of Owner (If other than Proposed Insured Employee)	
(____)Percentage	Licensed Agent	Signature of Interpreter (If Required by Proposed Insured Employee)	

NOTICE REGARDING REPLACEMENT OF YOUR LIFE INSURANCE POLICY OR ANNUITY

Are you thinking about buying a new life insurance policy/annuity and discontinuing/ changing an existing one? If so, your decision could be a good one or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits. Make sure you understand the facts. Ask the company or agent that sold you your existing policy to give you information about it. Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest. We are required by law to notify your existing company that you may be replacing their policy.

Applicant's Signature	Month/Day/Year	Agent's Signature	
AAW-APP1 (3/01)			TEXAS
	Part A, Page 2		

PART B - COMPLETE FOR ANY PROPOSED INSURED (EMPLOYEE) WHO IS APPLYING FOR MORE THAN THE SIMPLIFIED ISSUE LIMIT

11. Proposed Insured (Employee)'s Height: _____ Weight: _____
12. Has the Proposed Insured (Employee) ever been treated for the following: (If **Yes**, complete #16 and give details including name of the proposed insured, dates, diagnosis, outcome and the name and dosage of medications taken.):
- | | | | | | |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| a) Disorder of eyes, ears, nose, throat or skin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | g) Disorder of kidney, bladder, or genitourinary organs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) Dizziness, convulsions, headaches, or nervous disorders? | <input type="checkbox"/> | <input type="checkbox"/> | h) Diabetes, thyroid disorder, tumor, cancer or hernia? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Disorder of heart, blood vessels or lungs; chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | i) Disorder of muscles, bones, spine, back or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Sugar, albumin, blood or pus in urine? | <input type="checkbox"/> | <input type="checkbox"/> | j) Neuritis, sciatica, rheumatism, arthritis or gout? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Disorder of stomach, intestines, liver or gall bladder? | <input type="checkbox"/> | <input type="checkbox"/> | k) Are you currently taking medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Stroke, high blood pressure, heart murmur, heart attack, surgery or spleen? | <input type="checkbox"/> | <input type="checkbox"/> | l) Alcoholism, drug abuse, mental or physical disorders not listed? | <input type="checkbox"/> | <input type="checkbox"/> |
13. Other than above, has the Proposed Insured (Employee) within the past two years had a checkup, consultation, illness, injury or surgery? (If **Yes**, complete #16 and give details including dates, diagnosis, outcome and the name and dosage of medications taken.) Yes No
14. Within the past two years, has the Proposed Insured (Employee): a) flown in any aircraft other than as a passenger or b) engaged in any type of racing, parachuting or scuba diving activities? (If **Yes**, complete #17 and give details.) Yes No
15. Within the past two years, has the Proposed Insured (Employee) had a driver's license suspended or revoked Yes No
 If **Yes**, provide license # _____, State of Issue _____ and complete #17 and give details.

16. Details For #12 and #13 Answered "YES"

Proposed Insured's Name (First-MI-Last)	Question #	Medication, Disease & Injury	Date (Mo/Yr)	Details	Physician/Hospital/Address
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

17. Details for #14 and #15 Answered "YES"

TO BE DETACHED AND GIVEN TO APPLICANT - PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. We may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the bureau's file, you may seek a correction according to the procedures set forth in the Federal Fair Credit Reporting Act. The address of the bureau's information office is: PO Box 105, Essex Station, Boston, MA 02112 Telephone: 617-426-3660. Our reinsurers or we may also release information in our file to other life insurance companies to whom you may apply for life or health insurance.

NOTICE OF INSURANCE INFORMATION PRACTICES

Thank you for your application for insurance. We are glad to have the chance to participate in your insurance program. This notice tells you about the underwriting process. It also tells you how information is gathered to review your application. 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. We need this information to see if you qualify for insurance. The Authorization you signed will allow us to obtain this information and share it with others when necessary. No unnecessary disclosures will be made. Information will be treated as confidential by us and by our reinsurers. However, in some cases, information may be disclosed to others without your further consent. You have the right to review and to correct this information, and you have a right to get a copy of any investigative consumer report, which is made. If you want to know more about our underwriting practices and your rights, please write to Underwriting Department, Assurity Life Insurance Company, P. O. Box 80926, Lincoln, Nebraska 68501-0926.

Agent Signature _____ Agent Number _____

Your key to tomorrow...

Assurity at Work[®]

A division of Assurity Life Insurance Company
A member of the Lincoln Insurance Group

Short Term Disability Income Section

<input type="checkbox"/> OCCI <input type="checkbox"/> OCCII	Benefit per Month	Elimination Period	Benefit Period	Premium Amount
The following policies available on primary insured only:				
<input type="checkbox"/> Disability Income (Accident Only) OR				
<input type="checkbox"/> Non Occupational (Accident Only)	\$ _____	_____	_____	\$ _____
<input type="checkbox"/> Sickness Rider (Available on Disability Income and Non Occupational Only)	\$ _____	_____	_____	\$ _____
<input type="checkbox"/> Removal of Integration of Benefits Rider (Not Available on Non Occupational Policy)				\$ _____
Rider Insureds: <input type="checkbox"/> Employee <input type="checkbox"/> EE & Spouse <input type="checkbox"/> EE & Children <input type="checkbox"/> Family				

	Rider Benefit Amount			
<input type="checkbox"/> Accidental Death, Dismemberment & Paralysis Rider	EE\$ _____	SP\$ _____	CH\$ _____	\$ _____
<input type="checkbox"/> Intensive Care Unit Rider	\$ _____			\$ _____
<input type="checkbox"/> Injury Hospital Indemnity Rider OR				
<input type="checkbox"/> Hospital Indemnity Rider (Accident and Sickness)	\$ _____			\$ _____
<input type="checkbox"/> Private Duty Nurse Rider	\$ _____			\$ _____
<input type="checkbox"/> Surgical & Anesthesia Rider OR				
<input type="checkbox"/> Surgical & Anesthesia & Additional Benefits Rider	\$ _____			\$ _____
<input type="checkbox"/> Outpatient Sickness Rider	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$75	<input type="checkbox"/> \$100
<input type="checkbox"/> Emergency Accident Rider	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100	<input type="checkbox"/> \$150	<input type="checkbox"/> \$200
<input type="checkbox"/> Other _____	\$ _____			\$ _____
			Total Premium	\$ _____

Hospital Indemnity Section

Hospital Indemnity Plan - Employee	Benefit per Day	Elimination Period	Benefit Period	Premium Amount
Family Rider for Policy: <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Family	\$ _____	_____ days	<input type="checkbox"/> 180 days <input type="checkbox"/> 1 Year	\$ _____
Rider Insureds: <input type="checkbox"/> Employee <input type="checkbox"/> EE & Spouse <input type="checkbox"/> EE & Children <input type="checkbox"/> Family				

	Rider Benefit Amount			
<input type="checkbox"/> Accidental Death, Dismemberment & Paralysis Rider	EE\$ _____	SP\$ _____	CH\$ _____	\$ _____
<input type="checkbox"/> Injury Hospital Indemnity Rider OR				
<input type="checkbox"/> Hospital Indemnity Rider (Accident and Sickness)	\$ _____			\$ _____
<input type="checkbox"/> Intensive Care Unit Rider	\$ _____			\$ _____
<input type="checkbox"/> Private Duty Nurse Rider	\$ _____			\$ _____
<input type="checkbox"/> Annual First Occurrence Hospital Rider	\$ _____			\$ _____
<input type="checkbox"/> Surgical & Anesthesia Rider OR				
<input type="checkbox"/> Surgical & Anesthesia & Additional Benefits Rider	\$ _____			\$ _____
<input type="checkbox"/> Annual Wellness Benefit Rider				\$ _____
<input type="checkbox"/> Outpatient Sickness Rider	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	<input type="checkbox"/> \$75	<input type="checkbox"/> \$100
<input type="checkbox"/> Emergency Accident Rider	<input type="checkbox"/> \$50	<input type="checkbox"/> \$100	<input type="checkbox"/> \$150	<input type="checkbox"/> \$200
<input type="checkbox"/> Other _____	\$ _____			\$ _____
			Total Premium	\$ _____

The Proposed Insured Employee, if applying for more than one policy, may not elect the same rider to be attached to more than one policy. All insureds must have same rider benefits. All riders must have same insureds.

Cancer Section

Premium Amount

Cancer Expense Policy - Employee

Cancer Only **OR**

Cancer & Dread Disease

\$ _____

Hospital Indemnity Daily Benefit: \$150 \$250 \$350

Radiation/Chemotherapy Benefit: \$ 5,000 / \$ 25,000 \$ 5,000 / \$50,000 \$10,000 / \$ 50,000 \$10,000 / \$100,000

Family Rider for Policy: Spouse Children Family

\$ _____

Rider Insureds: Employee EE & Spouse EE & Children Family

Rider Benefit Amount

Cancer Only Intensive Care Unit Rider

\$300 \$600

\$ _____

Internal Cancer First Occurrence Benefit Rider:

\$2,500 \$5,000

\$ _____

Return of Premium Rider

Other _____

\$ _____

\$ _____

Total Premium

\$ _____

The Proposed Insured Employee, if applying for more than one policy, may not elect the same rider to be attached to more than one policy. All insureds must have same rider benefits. All riders must have same insureds.

AAW-APP-CA (4/01)

Accident Section

Premium Amount

Accident Expense Policy – Employee

One Unit; 1 1/2 Units; Two Units

\$ _____

Family Rider for Policy: Spouse Children Family

\$ _____

Rider Insureds: Employee EE & Spouse EE & Children Family

Rider Benefit Amount

Intensive Care Unit Rider

\$ _____

\$ _____

Private Duty Nurse Rider

\$ _____

\$ _____

Surgical & Anesthesia Rider **OR**

Surgical & Anesthesia & Additional Benefits Rider

\$ _____

\$ _____

Outpatient Sickness Rider

\$25

\$50

\$75

\$100

\$ _____

Other _____

\$ _____

\$ _____

Total Premium

\$ _____

The Proposed Insured Employee, if applying for more than one policy, may not elect the same rider to be attached to more than one policy. All insureds must have same rider benefits. All riders must have same insureds.

Term Life Section

The following policy available on primary insured only: 10-Year Level Term Plan

- Waiver of Premium Rider
- Accidental Death Rider

- Children's Term Rider
- Family Term Rider
- Critical Care Rider
- Other _____

Number of Units

Face Amount / Benefit Amount	Premium Amount
\$ _____	\$ _____
\$ _____	\$ _____
	\$ _____
	\$ _____
	\$ _____
Total Premium	\$ _____

Assurity Life Insurance Company
Disclosure – Accelerated Benefit Terminal Illness Rider

Rider Benefit – The Owner may request up to 50% of the Policy's Face Amount upon receipt of proof from a Physician diagnosing the Insured to have a terminal illness reasonably expected to result in the Insured's death within 12 months from the date an Accelerated Benefit is requested.

When the Accelerated Benefit is paid:

- We may charge a one-time administrative fee equal to 1% of the amount accelerated up to a maximum fee of \$150.
- Interest will be charged at a rate determined by Us not to exceed the greater of: (a) the current yield on 90 day treasury bills; (b) the current maximum adjustable loan interest rate based on Moody's Corporate Bond Yield averages or any successor; or (c) 8%; for each day from the period from the date of an Accelerated Benefit payment to the date of termination of the Policy. In no event will the interest rate exceed 10%. The Accelerated Benefit and any accrued interest will be treated as a lien.
- The Policy's Death Benefit will be reduced by the amount of the Accelerated Benefit payment plus any accrued interest and the administrative fee. If death occurs within one year from the date the Accelerated Benefit is paid, We will waive the administrative fee and the interest charges.
- At the time the accelerated benefit is paid, We will send the Owner a statement indicating the amount of benefits paid, the effect of the payment on the death benefit of the Policy to which the Rider is attached, the effect of the payment on future premiums, if any, and the amount of benefits remaining available for acceleration, if any.

Consequences of Receiving Accelerated Death Benefit – The Rider provides an accelerated benefit for terminal illness. The acceleration of life insurance benefits offered under the Rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as Your life expectancy at the time benefits are accelerated or whether You use the benefits to pay for necessary long-term care expenses such as nursing home care. If the acceleration of life insurance benefits qualifies for favorable tax treatment, the benefits will be excludable from Your income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive acceleration of life insurance benefits excludable from income under federal law. Receipt of Accelerated Benefits may affect the recipient's the recipient's spouse or the recipient's family's eligibility for government benefits and entitlements such as Medicaid, Aid to Families with Dependent Children (AFDC), Supplemental Social Security Income (SSI) and drug assistance programs. The recipient of a benefit is advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of said payment will affect the recipient's, the recipient's spouse or the recipient's family's eligibility for public assistance. We make no representations about the tax impact of the benefit.

Any irrevocable beneficiaries or assignee must send Us a written consent to the Accelerated Death Benefit payment. The written request must be in a form satisfactory to Us.

The total Accelerated Benefit, related charges, interest and liens, if any, plus the balance of the death benefit of the Policy to which the Rider is attached will constitute full settlement of the Policy's Face Amount.

When the lien plus the lien interest and any outstanding debt under the Policy equals the Policy Face Amount, coverage under the Rider and the Policy to which it is attached will terminate.

THE BENEFIT PAID UNDER THE RIDER WILL REDUCE THE POLICY'S DEATH BENEFIT AND OTHER VALUES UNDER THE POLICY TO WHICH THE RIDER IS ATTACHED.

I acknowledge that I have received and read this disclosure statement which was furnished to me prior to signing the application for insurance.

Signature of Proposed Insured/Owner

Date

Agent

Date

AAW 409 TX