

Alaska Application for Simplified Critical Illness Insurance

This application includes all forms needed to apply for Simplified Critical Illness Insurance.

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:

For Critical Illness products, the application should coincide with the **state in which the policy Owner resides** for the states listed below.

Simplified Critical Illness (Form CI 005): AR, CO, FL, ID, ME, MN, MT, NH, NC, ND, OK, PA, UT, WV Critical Illness (Form CI 007): AR, ID, ME, MT, NC, ND, OK, PA, UT, WV

All other applications should coincide with the **state where the application is signed**. State specific applications and state forms can be found on AssureLINK.

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity in the state coinciding with the application used.
- Print the application in black ink for faxing and photo copying purposes.
- Please verify that all questions on the application are answered. 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
 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 QUESTIONS RELATING TO UNDERWRITING (INCLUDING "WHAT IF" SCENARIOS) CALL TOLL FREE 800-276-7619, EXT. 4264 OR EMAIL TO underwriting@assurity.com.

Assurity Life Insurance Company Application for Critical Illness Insurance

I hereby apply for insurance with Assurity Life Insurance Company.

A. Proposed Insured

1. Name	. Name		3.a. Date of B b. Birth Stat		4. Age
5. Address			6. Social Secu	urity Number	
7. City, State, ZIP			8. Telephone	(Area Code/N	umber)
9. Height	Height 10. Weight 11. Best Time to Ca				
12. U.S. Citizen?	ow long has he or she been nanent visa?	en in the U.S No If Ye	.? es, please prov	ide a copy.	
13. Employer		_ Occupation	າ		
Duties					
14. Plan: Critical Illness	Benefit Amount:		lider(s)	eath Benefit	
	\$	[\$] Children's R		
Premium Payment Method:	Amount Collected:	ļ	☐ \$5,000 ☐ Return of Pro ☐ Spouse Ride		
Annually Quarterly Semi-Annually Monthly Other	\$		Benefit Amo	ount \$	
16. Name of spouse and/or dependent children Spouse and/or Children's Rider.	(who have not reached their	r 19 th birthday)	proposed for o	coverage unde	r the
	ex Date of /F Birth Ag	je Height	Weight	•	
SpouseM	∣				
Child M	□ □ F				
ChildM	∣				
ChildM	∣ □F				
17. Beneficiary Name	Relationship	SS	#/TIN	Date of Bir	th/Trust
Primary:					
Contingent:					

B. Answer the Following Questions:

1.	YE: Does the Proposed Insured(s) have any other Critical Illness (lump sum diagnostic benefits) coverage in force and applied for? If Yes , list company name and amount	S NO
2.	If under age 65, is the Proposed Insured(s) receiving Medicare or Medicaid?	
	If Yes , name of person(s)	
3.	Has the Proposed Insured(s) been postponed or declined Critical Illness coverage?	
	If Yes, name of person(s)	
4.	Has there been, or will there be, a lapse, surrender, loan, or other change to any existing health insurance as a of, or in anticipation of, this application?	
5.	Estimated Annual Income \$ Sources:	
C.	. Health History (Questions 1 through 6 apply to all Proposed Insured(s)):	S NO
1.		
2.	Has the Proposed Insured(s) ever received medical care from a member of the medical profession for, or been diagnosed with, any of the following? If Yes, indicate all that apply Stroke (including Transient Ischemic Attack) Diabetes Heart Attack Hepatitis B or C Alcoholism Chronic Lung Disease Drug Abuse Cirrhosis Cancer (other than skin cancer) Skin Cancer (2 or more occurrences) Melanoma Ulcerative Colitis Abnormal Kidney Functions Crohn's Disease Recurrent Human Papilloma virus (HPV) or Sexually Alzheimer's or Senile Dementia Transmitted Disease (within the past 5 years) Systolic Blood Pressure 150 or greater within the last 6 months Acquired Immune Deficiency Syndrome (AIDS), AIDS Diastolic Blood Pressure 95 or greater within the last 6 months JDiastolic Blood Pressure 95 or greater within the last 6 months	
3.	Does the Proposed Insured(s) intend to live or travel outside the United States or Canada for more than two months during the next 24 months?	
4.	 During the past two years has the Proposed Insured(s) been advised by a member of the medical profession: a) of any abnormal diagnostic test results or been advised to have any diagnostic tests (includes self-administered) which have not yet been completed? b) to undergo any treatment, hospitalization or surgery which has not yet been completed? 	
5.	During the past five years, has the Proposed Insured been unable to perform any of the following activities on his/her own: transferring in or out of a chair or bed, dressing, bathing, feeding, toileting or continence?	
6.	 Have any two or more of the Proposed Insured's natural parents, brothers or sisters, either living or deceased, been diagnosed with the same condition(s) from the following list: Heart disease, stroke, diabetes, kidney disease or breast cancer prior to age 60? Colorectal cancer or Alzheimer's or Senile Dementia prior to age 75? Any other same cancer in both relatives prior to age 55? 	
	If any question in this section (Section C, Questions $1 - 5$) is answered "Yes", list the name(s) of the person(s).	
7.	Has the Proposed Insured(s) used any tobacco or nicotine product during the past 12 months?	

lf	"Yes",	list	name	s):

D. AGREEMENT

I HEREBY AGREE THAT: 1. All answers in this Application : (a) are true and complete to the best of my knowledge; and (b) will be relied on to determine insurability. 2. If the minimum premium deposit is paid on the date this Application is signed, the policy applied for will be in effect from that date, subject to: (a) underwriting requirements; (b) the terms of the attached Conditional Receipt; (c) the terms of the policy and (d) the issuing Company's right to rescind the policy. The minimum premium deposit is the amount equal to the full premium for the mode chosen on this application for the policy applied for. 3. If the minimum premium deposit is not paid as provided in "2 (b)" above, then no insurance will be in effect unless: (a) during the lifetime of the Proposed Insured, a policy is delivered to the Proposed Insured/Owner and accepted and the entire first premium is paid; and (b) at the time of delivery or acceptance or payment, whichever is later, all answers in this Application are still true and complete to the best of my knowledge. 4. No agent is authorized to waive the terms of this Agreement.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Dated at		th	nis	day of		
	City	State	Day		Month	Year
				Witnessed by		
	(Signature of Prop	osed Insured)		,	(Licensed Resid	dent Agent)
				Assurity Agent N	Number	
	(Signature of	Spouse)		, ,		

FIELD UNDERWRITER'S STATEMENT

1.	What amount was collected with this application? \$		
2.	Has a Conditional Receipt been given to the Proposed Insured?	🗌 Yes	□No
3.	Did you personally see the Proposed Insured/Owner on date of application? (If "No," please explain in #6)	🗌 Yes	□No
4.	Is the Proposed Insured/Owner a citizen of the United States? If "No," provide a copy of their permanent visa.	🗌 Yes	□No
5.	If this insurance is issued, will it replace any insurance, annuity, or other policy? (If "Yes," please explain in #6.)	🗌 Yes	□No
6.	Special Requests, Remarks, and Instructions:	Was this appli faxed?()Y If "yes", give o	()N

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.

 Soliciting Agent Signature
 Code Number
 Date

 Soliciting Agent Printed Name
 Agent Phone Number
 Agent Fax Number and/or Email Address

Automatic Bank Withdrawal

	nium from your checking account – saving you time and money. To begin this
	to us with a voided check . Remember to indicate the date of withdrawal that would
be most chronient for you.	··· · · · · · · · · · · · · · · · · ·
I hereby request and outporte Assuring his insurance Company, authorization shall remain in effect unit levels of hone in the mar	, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This neer provided by law, 1 Intil it receives notice of such revocation. Lagree that
Assurity Life Insurance Company shall be fully preceded in Vone	, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This nner provided by law. Until it receives notice of such revocation, I agree that in the account.
Date of Withdrawal: (cannot be the 29 th , 30 th or 31 st ; I	IF NO DATE IS ENTERPOLICY ISSUE DATE WILL BE USED.) WIUM FOR THIS INSURANCE WILL BE DEBREN ROSYOUR ACCOUNT AT THE POLICY IS ISSUED.
Draft initial premium payment: Yes No FIRST PREM THE TIME TH	VIUM FOR THIS INSURANCE WILL BE DEBLEN RONSYOUR ACCOUNT AT
DO NOT SIGN	• • • • • • • • • • • • • • • • • • • •
Signature of Account Holder	Telephone Number Date Signed
Cover the charging of future premiums; 5/coveragy inder we be account will be credited if I make use of the Policy's Righuo Cara application is accepted. Name on Card Card/Account Number Do NOT SIGN	card listed below in the amount of \$ for the first premium on the policy the use of the credit card for payments is optional: 2) this authorization does not licy begins only as specified in the Conditional Receipt I have received; 4) my charles of the credit card for payments is optional: 2) this authorization does not licy begins only as specified in the Conditional Receipt I have received; 4) my charles of the credit card for payments is optional: 2) this authorization does not solve the credit card for payments is optional: 2) this authorization does not when the accompanying the credit card for payments is optional: 2) this authorization does not specific the credit card for payments is optional: 2) this authorization does not may be accompanying the companying the credit card for payments is optional: 2) this authorization does not card the credit card for payments is optional: 2) this authorization does not may be accompanying the companying the companying the credit card for payments and the companying the companying the companying the compan
Signature of Card Holder	
CONDI	TIONAL RECEIPT
	ife Insurance Company
•	Street, P.O. Box 82533
	Nebraska 68501-2533
Toll Fr	ree 1-800-276-7619
Make all premium checks payable to Assurity Life the agent or leave "payee" blank.	e Insurance Company. Please do not make checks payable to
Received from	with the attached Application to Assurity Life
Insurance Company the sum of \$	as payment of the first premium for the critical

illness insurance applied for	

- a. If the first premium acknowledged by this Conditional Receipt is paid on or before the date the Application was signed; and
- If, on the date the Application was signed, the Proposed Insured was insurable without special exception and at standard rates under the Company's underwriting rules and practices for the insurance applied for;

the Company agrees to insure the Proposed Insured(s) under this Conditional Receipt. The amount of insurance hereunder will be the lesser of the amount applied for, or the amount for which the Proposed Insured qualifies, but not to exceed \$50,000 for any individual applying for critical illness insurance with the Company.

This Conditional Receipt terminates the earlier of a) 60 days after the date the Application was signed, or b) the date the insurance applied for becomes effective. If one or more of the conditions are not met, the Company's liability will be limited to the return of the sum received. This Conditional Receipt is controlled by the terms of the policy applied for. No agent is authorized to change or alter this Conditional Receipt.

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ASSURITY[®]LIFE INSURANCE COMPANY

Post Office Box 82533, Lincoln, NE 68501-2533 (402) 476-6500 • (800) 276-7619

Name of Applicant		Date of Birth (MM/DD/YYYY)	
Name of Additional App	licant/Insured/Claimant (Please print)		/ / Date of Birth (MM/DD/YYYY)
Applicant/Insured/Claimant Child(ren) Name	Date of Birth	Name	Date of Birth
, on behalf of myself or the person name	ed above (Individual), authorize any lice	nsed physician, medical prac	titioner, hospital, clinic, pharmacy o

I, on behalt of myself or the person named above (Individual), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (MIB), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company (Assurity), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from the MIB):

- 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 (*Except information about human immunodeficiency virus (HIV) infection for Individuals residing in Maine or Vermont.). For residents of Maine: this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. For residents of Vermont: this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.*
- 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 session 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.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in 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 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, the Medical Information Bureau (*MIB*), 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 re-disclosure 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.

This authorization is valid for twenty-four (24) months from the date of signature below (*Except for residents of Arizona, 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)





ASSURITY[®]LIFE INSURANCE COMPANY

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Name of Applicant		Date of Birth (MM/DD/YYYY)	
Name of Additional App	licant/Insured/Claimant (Please print)		/ / Date of Birth (MM/DD/YYYY)
Applicant/Insured/Claimant Child(ren) Name	Date of Birth	Name	Date of Birth
, on behalf of myself or the person name	ed above (Individual), authorize any lice	nsed physician, medical prac	titioner, hospital, clinic, pharmacy o

I, on behalt of myself or the person named above (Individual), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (MIB), consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company (Assurity), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from the MIB):

- 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 (*Except information about human immunodeficiency virus (HIV) infection for Individuals residing in Maine or Vermont.). For residents of Maine: this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. For residents of Vermont: this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.*
- 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 session 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.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in 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 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, the Medical Information Bureau (*MIB*), 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 re-disclosure 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.

This authorization is valid for twenty-four (24) months from the date of signature below (*Except for residents of Arizona, 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.

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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)





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[®]LIFE INSURANCE COMPANY

Post Office Box 82533, Lincoln, NE 68501-2533 (402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Automatic PREMIUM PAYMENT

Name of Proposed Insur	ed		Middle	Last		Date Signed	/ / (MM/DD/YYYY)
Policy No. (if for an exist	ina policv)						(
AUTOMATIC BANK V		AUTHORIZAT	ION			_	
Name of Account Holder	or Authorized C	officer					
□ Initial and recurring			ing premiums only				
If "Initial and recurring pre the policy is issued. No co	emiums" is marl	ed, the compa	ny's authority to debit	from your accou	nt the first premium fo	r this insurance doe	s not begin until the date
Type of Account: 🔲 Ch	necking	Savings	5				
Date of Withdrawal	Date c	annot be the 29	9 th , 30 th or 31 st . If no d	ate is entered, th	ne policy issue date w	ill be used.	
I hereby request and au selected above. I unde remain in effect until revo be fully protected in ho premium is not honored	rstand that init ked by me in th noring any deb	iating automat e manner provi it to my accou	ic payments may re ded by law. Until it rec unt. I further underst	sult in addition eives notice of s and that if the o	al drafts to bring my uch revocation, I agree date of the withdrawa	account current. e that Assurity Life Ir al is after the polic	This authorization shall isurance Company shall
	Name of Fina	ncial Institution		Routi	ing No. (9-digit number)		Account No.
					1 1	()	
Signature o	f Account Holder	or Authorized O	fficer and Title	D	l l Date (MM/DD/YYYY)		elephone No.
CREDIT CARD AUTH			(unless application i		IT VOIDED CHECK tronically)	κ.	
□ Initial premium only			miums only		d recurring premiums		
If "Initial premium only" card does not begin until	or "Initial and re	ecurring premi	ums" is marked, the	company's autho	prity to charge the first		nsurance to your credit
Type of Card: 🔲 Maste	erCard	🗌 Visa	Discover				
5 –] 1 st no date is sele	5 th	10 th	□ 15 th he option date in	□ 20 th nmediately prior to the	25 th policy issue date.	
I hereby request and au selected above. I unde remain in effect until re Company shall be fully date and if any premium	uthorize Assuri rstand that init woked by me protected in ho	y Life Insuran iating automat in the manner noring any cha	ce Company, Lincol ic payments may re provided by law. U rges to my credit ca	n, Nebraska, to sult in addition ntil it receives r d. I further unde	initiate charges to m al drafts to bring my notice of such revoca erstand that if the dat	y credit card listed account current. ation, I agree that e of the withdrawal	This authorization shall Assurity Life Insurance is after the policy issue
Na	me as it appears	on Card (Please	print)		Card/Account No.	Expiratio	n Date (MM/YYYY)
Credit card billing addres	SS						
0	Street Addre	ess	P.O. Box		City	State	Zip+4
Signatura	f Account Holder	or Authorized O	fficer and Title		 Date (MM/DD/YYYY)	()	elephone No.
Signature o	n Account Holder	or Authorized U	IIICEI AIIU IILIE	L	ale (IVIIVI/DD/YYY)	10	лерноне по.
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