



Toll Free: 1-800-276-7619, Ext. 4264

AssureLINK Address: <http://assurelink.assurity.com>

## Maine 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
  1. 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](mailto: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 _____   | 2. Sex<br><input type="checkbox"/> M <input type="checkbox"/> F | 3. a. Date of Birth<br>b. Birth State _____   | 4. Age _____     |              |        |         |                                   |                          |
| 5. Address _____  |   | 6. Social Security Number _____   |                  |              |        |         |                                   |                          |
| 7. City, State, ZIP _____   |   | 8. Telephone (Area Code/Number) _____   |                  |              |        |         |                                   |                          |
| 9. Height _____   | 10. Weight _____  | 11. Best Time to Call _____   |                  |              |        |         |                                   |                          |
| 12. U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, how long has he or she been in the U.S.? _____<br>If not a citizen, does he or she have a permanent visa? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide a copy. |   |   |                  |              |        |         |                                   |                          |
| 13. Employer _____ Occupation _____<br>Duties _____   |   |   |                  |              |        |         |                                   |                          |
| 14. Plan: <b><u>Critical Illness</u></b>  |   | 15. Rider(s)  |                  |              |        |         |                                   |                          |
| Benefit Amount:<br>\$ _____   |   | <input type="checkbox"/> Accidental Death Benefit<br>\$ _____   |                  |              |        |         |                                   |                          |
| Premium Payment Method:<br><input type="checkbox"/> Annually <input type="checkbox"/> Quarterly<br><input type="checkbox"/> Semi-Annually <input type="checkbox"/> Monthly<br><input type="checkbox"/> Other _____  |   | <input type="checkbox"/> Children's Rider<br><input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000<br><input type="checkbox"/> Return of Premium<br><input type="checkbox"/> Spouse Rider<br>Benefit Amount \$ _____<br><input type="checkbox"/> Waiver of Premium |                  |              |        |         |                                   |                          |
| Amount Collected:<br>\$ _____   |   |   |                  |              |        |         |                                   |                          |
| 16. Name of spouse and/or dependent children (who have not reached their 19 <sup>th</sup> birthday) proposed for coverage under the Spouse and/or Children's Rider.   |   |   |                  |              |        |         |                                   |                          |
| Full Name   | Relationship  | Sex<br>M/F  | Date of<br>Birth | Age          | Height | Weight  | Residing with<br>Proposed Insured |                          |
| _____   | Spouse  |   |                  |              |        |         | <b>Yes</b>                        | <b>No</b>                |
|   |   |   |                  |              |        |         | <input type="checkbox"/>          | <input type="checkbox"/> |
| _____   | Child   |   |                  |              |        |         | <input type="checkbox"/>          | <input type="checkbox"/> |
| _____   | Child   |   |                  |              |        |         | <input type="checkbox"/>          | <input type="checkbox"/> |
| _____   | Child   |   |                  |              |        |         | <input type="checkbox"/>          | <input type="checkbox"/> |
| 16. Beneficiary Name  |   |   |                  | Relationship |        | SS#/TIN |                                   | Date of Birth/Trust      |
| Primary: _____  |   |   |                  |              |        |         |                                   |                          |
| Contingent: _____   |   |   |                  |              |        |         |                                   |                          |

**B. Answer the Following Questions:**

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Does the Proposed Insured(s) have any other Critical Illness (lump sum diagnostic benefits) coverage in force and applied for? If <b>Yes</b> , list company name and amount. .... | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/>  |                          |                          |
| 2. If under age 65, is the Proposed Insured(s) receiving Medicare or Medicaid? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If <b>Yes</b> , name of person(s) _____  |                          |                          |
| 3. Has the Proposed Insured(s) been postponed or declined Critical Illness coverage? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| If <b>Yes</b> , 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 result of, or in anticipation of, this application? .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Estimated Annual Income \$ _____ Sources: _____   |                          |                          |

**C. Health History (Questions 1 through 6 apply to all Proposed Insured(s)):**

- |  | YES                      | NO  |
|--|--------------------------|---|
| 1. During the past two years, has the Proposed Insured(s) received medical care from a member of the medical profession for, or experienced symptoms of, any of the following? If Yes, indicate all that apply. ....   | <input type="checkbox"/> | <input type="checkbox"/>  |
| <input type="checkbox"/> Disorder of the heart or circulatory system<br><input type="checkbox"/> Unexplained weight loss<br><input type="checkbox"/> Fibrocystic breast disease, recurrent breast tumors or unexplained tumors/growths   |                          | <input type="checkbox"/> Unexplained fatigue<br><input type="checkbox"/> Unexplained dizziness<br><input type="checkbox"/> Abnormal Pap smear   |
| 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. ....   | <input type="checkbox"/> | <input type="checkbox"/>  |
| <input type="checkbox"/> Stroke (including transient ischemic attack)<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Drug abuse<br><input type="checkbox"/> Cancer (other than skin cancer)<br><input type="checkbox"/> Melanoma<br><input type="checkbox"/> Abnormal kidney functions<br><input type="checkbox"/> Recurrent human papilloma virus (HPV) or sexually transmitted disease within the past 5 years (except for HIV)<br><input type="checkbox"/> Acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or any AIDS-related condition (If you test positive for HIV but have not developed symptoms of the disease AIDS, do not check this box. |                          | <input type="checkbox"/> Diabetes<br><input type="checkbox"/> Hepatitis B or C<br><input type="checkbox"/> Chronic lung disease<br><input type="checkbox"/> Cirrhosis<br><input type="checkbox"/> Skin cancer (2 or more occurrences)<br><input type="checkbox"/> Ulcerative colitis<br><input type="checkbox"/> Crohn's disease<br><input type="checkbox"/> Alzheimer's or senile dementia<br><input type="checkbox"/> Systolic blood pressure 150 or greater within the last 6 months<br><input type="checkbox"/> Diastolic 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? .....   | <input type="checkbox"/> | <input type="checkbox"/>  |
| 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, but excludes HIV testing) which have not yet been completed? .....  | <input type="checkbox"/> | <input type="checkbox"/>  |
| b) to undergo any treatment, hospitalization or surgery which has not yet been completed? .....  | <input type="checkbox"/> | <input type="checkbox"/>  |
| c) to refer to a specialist and have not yet done so? .....  | <input type="checkbox"/> | <input type="checkbox"/>  |
| If <b>Yes</b> , which specialty: _____   |                          |   |
| 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? ....   | <input type="checkbox"/> | <input type="checkbox"/>  |
| 6. Have any <b>two or more</b> of the Proposed Insured's natural parents, brothers or sisters, either living or deceased, been diagnosed with the <b>same condition(s)</b> from the following list:  |                          |   |
| • Heart disease, stroke, diabetes, kidney disease or breast cancer prior to age 60? .....  | <input type="checkbox"/> | <input type="checkbox"/>  |
| • Colorectal cancer, Alzheimer's or senile dementia prior to age 75? .....   | <input type="checkbox"/> | <input type="checkbox"/>  |
| • Any other same cancer in both relatives prior to age 55? .....   | <input type="checkbox"/> | <input type="checkbox"/>  |
| If any question in this section (Section C, Questions 1 – 5) is answered "Yes," list the name(s) of the person(s).<br>_____  |                          |   |
| 7. Has the Proposed Insured(s) used any tobacco or nicotine product during the past 12 months? .....   | <input type="checkbox"/> | <input type="checkbox"/>  |
| If <b>Yes</b> , list name(s): _____  |                          |   |



## Automatic Bank Withdrawal

Automatic Bank Withdrawal conveniently pays your monthly premium from your checking account – saving you time and money. To begin this convenient service, please complete the form below and return it to us with a **voided check**. Remember to indicate the date of withdrawal that would be most convenient for you.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account.

Date of Withdrawal: \_\_\_\_\_ (cannot be the 29<sup>th</sup>, 30<sup>th</sup> or 31<sup>st</sup>; IF NO DATE IS ENTERED THE POLICY ISSUE DATE WILL BE USED.)

Draft initial premium payment:  Yes  No FIRST PREMIUM FOR THIS INSURANCE WILL BE DEBITED FROM YOUR ACCOUNT AT THE TIME THE POLICY IS ISSUED.

**DO NOT SIGN**

\_\_\_\_\_  
Signature of Account Holder

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date Signed

## Credit Card Authorization

I authorize Assurity Life Insurance Company to charge the credit card listed below in the amount of \$\_\_\_\_\_ for the first premium on the policy or policies for which I am applying. In this date, I acknowledge 1) the use of the credit card for payments is **optional**; 2) this authorization does not cover the charging of future premiums; 3) coverage under the policy begins only as specified in the Conditional Receipt I have received; 4) my account will be credited if I make use of the Policy's Right of Cancel Provision; and 5) this charge will be initiated only when the accompanying application is accepted.

\_\_\_\_\_  
Name on Card

\_\_\_\_\_  
Card/Account Number

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Date of Signature

**DO NOT SIGN**

Mastercard

Visa

Discover

\_\_\_\_\_  
Signature of Card Holder

## CONDITIONAL RECEIPT

### Assurity Life Insurance Company

1526 K Street, P.O. Box 82533

Lincoln, Nebraska 68501-2533

Toll Free 1-800-276-7619

Make **all** premium checks payable to Assurity Life Insurance Company. Please **do not** make checks payable to the agent or leave "payee" blank.

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
- b. 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent



\_\_\_\_\_  
*Name of Applicant/Insured/Claimant (Please print)*

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

\_\_\_\_\_  
*Name of Additional Applicant/Insured/Claimant (Please print)*

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

| Applicant/Insured/Claimant Child(ren) |               |       |               |
|---------------------------------------|---------------|-------|---------------|
| Name                                  | Date of Birth | Name  | Date of Birth |
| _____                                 | _____         | _____ | _____         |
| _____                                 | _____         | _____ | _____         |
| _____                                 | _____         | _____ | _____         |

I, on behalf 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 or employer 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 or avocations.
- Information on the diagnosis or treatment of sexually transmitted diseases (***EXCEPT information about human immunodeficiency virus (HIV) infection***). **\*This authorization excludes disclosure of the results of a test for HIV if the Applicant 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 Applicant has AIDS.**
- 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 (*excluding HIV*) 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 or employer that has any records of the \*Individual's health to release and disclose the Individual's entire medical record as described above. 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, 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 or revoke this authorization, Assurity will not be able to process this application, or if coverage has been issued, will 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)*





\_\_\_\_\_  
*Name of Applicant/Insured/Claimant (Please print)*

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

\_\_\_\_\_  
*Name of Additional Applicant/Insured/Claimant (Please print)*

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

| Applicant/Insured/Claimant Child(ren) |               |       |               |
|---------------------------------------|---------------|-------|---------------|
| Name                                  | Date of Birth | Name  | Date of Birth |
| _____                                 | _____         | _____ | _____         |
| _____                                 | _____         | _____ | _____         |
| _____                                 | _____         | _____ | _____         |

I, on behalf 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 or employer 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 or avocations.
- Information on the diagnosis or treatment of sexually transmitted diseases (***EXCEPT information about human immunodeficiency virus (HIV) infection***). **\*This authorization excludes disclosure of the results of a test for HIV if the Applicant 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 Applicant has AIDS.**
- 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 (*excluding HIV*) 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 or employer that has any records of the \*Individual's health to release and disclose the Individual's entire medical record as described above. 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, 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 or revoke this authorization, Assurity will not be able to process this application, or if coverage has been issued, will 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](http://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.







**NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH INSURANCE**

According to your application (*information you have furnished*), you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Assurity Life Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions that you may presently have (*pre-existing conditions*), may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all relevant factors involved in replacing your present coverage.
3. Do not cancel your present policy until you have actually received your new policy and are sure you want to keep it.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

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

\_\_\_\_\_ *Applicant's Signature and Printed Name*

**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.**





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2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all relevant factors involved in replacing your present coverage.
3. Do not cancel your present policy until you have actually received your new policy and are sure you want to keep it.
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**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

## SPECIFIED DISEASE COVERAGE

### THIS POLICY PROVIDES LIMITED BENEFITS

### BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

### OUTLINE OF COVERAGE

### FORM NO. CI 005 (ME)

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“We” are **Assurity Life Insurance Company**, the company providing this Outline of Coverage. The address is P.O. Box 82533, Lincoln, Nebraska, 68501-2533. We are required to give You the following information:

- This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless You have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer’s Guide to Cancer Insurance to review the possible limits on benefits in this type of coverage.
- **READ YOUR POLICY CAREFULLY.** This Outline of Coverage provides a very brief description of the important features of coverage. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**
- **SPECIFIED DISEASE COVERAGE** is designed to provide restricted coverage paying benefits **ONLY** when certain losses occur as a result of specified disease. Coverage is **NOT** provided for other diseases or accidents.
- This **IS NOT A MEDICARE SUPPLEMENT** Policy. If You are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

**THIS IS A LIMITED BENEFIT POLICY!**

## **POLICY BENEFITS**

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While Your Policy is in force, We will pay You the Benefit Amount if You receive a First Ever Diagnosis or Procedure for one of the following Specified Covered Conditions:

| <b>Specified Disease Covered Condition</b> | <b>Percentage of Maximum Benefit Payable</b> |
|--|--|
| a) Invasive Cancer                         | 100%   |
| b) Heart Attack                            | 100%   |
| c) Stroke                                  | 100%   |
| d) Major Organ Transplant                  | 100%   |
| e) End-Stage Renal Disease                 | 100%   |
| f) Advanced Alzheimer's Disease            | 100%   |
| g) Major Burns                             | 100%   |
| h) Paralysis                               | 100%   |
| i) Coma                                    | 100%   |
| j) Coronary Bypass Surgery                 | 25%  |
| k) Cancer in Situ                          | 25%  |
| l) Angioplasty                             | 10%  |

and;

If a portion of the Maximum Benefit Amount is paid under the Policy or certain attached Riders (if applicable), the Maximum Benefit Amount will be reduced by the amount paid, and the premium will be adjusted accordingly. The Owner will be notified of the new Maximum Benefit Amount and new Premium. In no event will the payment(s) for any Specified Disease Insured Condition(s) exceed the Maximum Benefit Amount then in force.

Definitions of each Specified Covered Condition or Procedure are found in Your Policy.

## **LIMITATIONS**

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- The Benefit Amount for Coronary Bypass Surgery and Cancer in Situ is 25% of the Maximum Benefit Amount. The Benefit Amount for Angioplasty is 10% of the Maximum Benefit Amount.
- For Invasive Cancer, a reduced benefit equal to 10% of the Maximum Benefit Amount will be paid if the First Ever Diagnosis is made anytime within 30 days following the Issue Date of the Policy. For Cancer in Situ, a reduced benefit equal to 2.5% of the Maximum Benefit Amount will be paid if the First Ever Diagnosis is made anytime within 30 days following the Issue Date of the Policy.

## **EXCLUSIONS**

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We will not pay a Benefit Amount for a Specified Covered Condition or Procedure resulting from

- participating in or attempting to commit a felony;
- engaging in an illegal occupation;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide, whether sane or insane; or
- involvement in any period of armed conflict, whether declared or not.

## **PREMIUMS**

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The first Premium is due on the Date of issue. Premiums due after the first Premium are Renewal Premiums. Renewal Premiums are paid at the Premium payment interval. You can change this. The date the next Renewal Premium is due is the Due Date. Renewal Premiums are paid before the Due Date.

You have a Grace Period to pay Renewal Premium payments. The Grace Period starts on the Due Date and ends 31 days later. During the Grace Period, Your Policy stays in force. If You do not pay the Renewal Premium by the end of the Grace Period, Your Policy will end for non-payment of Premium.

If Your Policy ends because You did not pay a Renewal Premium, You can ask to have the Policy put back in force. This is called Reinstatement. You must ask for Reinstatement within 2 years of the lapse of Your Policy. We will decide if the Policy is put back in force. The Reinstated Policy will only pay a Benefit Amount for First Ever Diagnosis of Covered Specified Diseases or Procedures that happen after the Policy has been put back in force.

**RENEWABILITY**

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This Policy is Guaranteed Renewable to age 75. That means until the Policy anniversary following Your age 75, We cannot cancel or change Your Policy as long as You pay Premiums. We can change the Premium rates. If We do this, We can only do it to all Policies in Your class, with Your state's approval.

**RIGHT TO CANCEL**

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You may cancel the Policy within 30 days of receiving it. Return the Policy to Assurity's Home Office or Your Assurity sales agent. As soon as You deliver or mail the Policy to Us, it is treated as if it was never issued. We will give back Your Premium payment. After the first 30 days, You may cancel this Policy at any time by telling Us in writing. The Policy will be cancelled on the date We receive Your written notice or the date You tell Us in Your notice. We will give back any unearned Premium.

**THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED.  
CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.**