



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

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

## Rhode Island 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>  |                  | Benefit Amount:<br>\$ _____                                     |   | 15. Rider(s)<br><input type="checkbox"/> Accidental Death Benefit<br>\$ _____<br><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 |        |        |  |                          |
| 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 _____  |                  | 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 Birth                               | Age  | Height | Weight | Residing with Proposed Insured<br><b>Yes</b> <b>No</b> |                          |
| _____   | Spouse           | <input type="checkbox"/> M <input type="checkbox"/> F           | _____                                       | _____  | _____  | _____  | <input type="checkbox"/>                               | <input type="checkbox"/> |
| _____   | Child            | <input type="checkbox"/> M <input type="checkbox"/> F           | _____                                       | _____  | _____  | _____  | <input type="checkbox"/>                               | <input type="checkbox"/> |
| _____   | Child            | <input type="checkbox"/> M <input type="checkbox"/> F           | _____                                       | _____  | _____  | _____  | <input type="checkbox"/>                               | <input type="checkbox"/> |
| _____   | Child            | <input type="checkbox"/> M <input type="checkbox"/> F           | _____                                       | _____  | _____  | _____  | <input type="checkbox"/>                               | <input type="checkbox"/> |
| 17. 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)<br><input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus infection (symptomatic or asymptomatic) or any AIDS related condition | <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) 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"/> |
| 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 or 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 "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 \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ Year  
City State Day Month

\_\_\_\_\_  
(Signature of Proposed Insured) Witnessed by \_\_\_\_\_  
(Licensed Resident Agent)  
\_\_\_\_\_  
(Signature of Spouse) Assurity Agent Number \_\_\_\_\_

**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?.....  Yes No  
If "No," provide a copy of their permanent visa.
- 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 application faxed? ( ) Y ( ) N  
If "yes", give date.  
\_\_\_\_\_

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

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 withdrawing 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. On 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, 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)*





\_\_\_\_\_  
*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, 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)*





## 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**

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

1. Health conditions that you may presently have (*pre-existing conditions*), may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present contract 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 contract 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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