



## Wyoming Application

This application includes all forms needed to apply for Single Premium Endowment to Age 110.

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:

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity in the policy Owner's\* "State of Residence".
- ✓ Use the appropriate application for the state in which the policy Owner\* resides. Applications and state forms may be ordered from Legacy.
- ✓ 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 are not acceptable.)
- ✓ Review the Conditional Receipt for collection limits. (If Proposed Insured has a history of heart trouble, stroke, or cancer, do not collect the initial premium.)
- ✓ Complete appropriate replacement form:  
External/Internal: LIFE Repl-WY-99
- ✓ **If faxing directly to Legacy, fax to 402-493-3507**
- ✓ **If mailing directly to Legacy, address to: Legacy Insurance Services, Inc. of America  
741 N 120<sup>th</sup> Street  
Omaha NE 68154-4212**

# Insurance Application to Assurity Life Insurance

I represent that these statements are true and complete to the best of my knowledge and belief. I agree that this application will be the basis for and part of the policy that is issued; and that coverage will begin on the effective date in the policy if the premium has been paid during the Proposed Insured's lifetime and while his/her insurability remains as stated on this application

## A. General Information on the Proposed Insured

1. A. Proposed Insured's Full Name (please print)	B. Sex	C. Date of Birth	D. Age	E. Birthplace	F. Social Security No.	G. Height	H. Weight
I. Residence Address	J. City	K. State	L. Zip	M. Telephone Number	N. Occupation		
2. A. Name and Address of Personal Physician						B. Physician's Telephone Number	
3. A. Primary Beneficiary	B. Relationship		C. Address				
4. A. Contingent Beneficiary	B. Relationship		C. Address				
5. A. Owner (if other than the Proposed Insured)	B. Relationship		C. Social Security Number			D. Date of Birth	
6. Is this policy being purchased to replace any existing insurance? (If Yes, or "1035 Exchange", list company, policy number and address.) <input type="checkbox"/> Yes <input type="checkbox"/> No							
7. A. Plan: <b>Single Premium Whole Life</b> <input type="checkbox"/> Accidental Death Benefit Rider <input type="checkbox"/> Single Premium Whole Life – Last Survivor			B. Face Amount			D. Premium Mode <b>Single Premium</b>	
			C. Amount Paid				

## B. Health History

- |  |                          | Yes                      | No                       |
|--|--------------------------|--------------------------|--------------------------|
| 1. Has the Proposed Insured:   |                          |                          |                          |
| a. Been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Tested positive for antibodies to the AIDS virus or been advised not to give blood? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has the Proposed Insured consulted a physician or been treated (including prescription medications) within the past five (5) years for:     |                          |                          |                          |
| a. Cancer, leukemia or melanoma, systemic lupus, or has the Proposed Insured had more than one occurrence of cancer in his/her lifetime? ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart disease, heart surgery, stroke or any heart or circulatory disorder (except high blood pressure under control by medication)? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Diabetes, kidney disease, liver disease or organ transplant? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Emphysema or any other lung disorder requiring oxygen? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Alzheimer's Disease, dementia, nervous disorder or mental disorder? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is the Proposed Insured currently under treatment or taking prescription medication? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has the Proposed Insured ever sought treatment for alcoholism or drug abuse? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the Proposed Insured had life or health insurance declined, non-renewed, rated, modified, postponed or cancelled? .....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is the Proposed Insured bedridden at home or confined to a hospital, nursing home or long-term care facility? .....                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the Proposed Insured used any form of tobacco or nicotine-based products in the last 12 months? .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Give complete details in the space provided below for all questions answered Yes. Attach separate sheet if necessary and be sure it is signed and dated.**

Question Number	Date(s) of Treatment	Provide reason(s) for consultation(s), names(s) and addresses and phone number(s) of physician(s) and include details of treatment prescribed, result(s) of consultation(s), and medication(s) prescribed.

- 8. Has the Proposed Insured engaged in or plan to engage in flying as a pilot, student, or crew member, underwater diving, hang gliding, ultralight flying, skydiving, parachuting, ballooning, bungee jumping or mountain or rock climbing?
- 9. Does the Proposed Insured currently have an application for insurance pending with any other company?    
If Yes, please explain: \_\_\_\_\_
- 10. List life insurance and annuity policies in force on the life of the Proposed Insured:

Company	Policy Number	Year Issued	Plan	Amount	ADB Amount	Replaced

I (WE) AGREE THAT

- A. I (We) have read the above questions and answers and declare that they are complete and true to the best of my (our) knowledge and belief. I (We) agree that this application (Part I – General Section, pages 1 and 2, Part II – Medical (if required), Traditional Product Life Section/ Flexible Premium Universal Life Section, and Avocation Questionnaire (if required)) shall form a part of the policy if attached thereto.
- B. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Conditional Receipt delivered by the Company’s agent in exchange for such payment.
- C. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless the application is approved by the Company at its Home Office, such policy issued and delivered to the Proposed Insured/Owner, and such first full premium paid during the Proposed Insured’s lifetime and continued good health and the lifetime and continued good health of any other person(s) covered under the policy, and when such approval, issue, delivery, and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.
- D. No agent or medical examiner has power or is authorized to change or waive any term, provision or condition of this application, the Conditional Receipt, or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

Witnessed by \_\_\_\_\_ **X** \_\_\_\_\_  
 Licensed Resident Agent Signature of Proposed Insured

Agency No. \_\_\_\_\_ **X** \_\_\_\_\_  
 Signature of owner (if not Proposed Insured)

**Agreement for the Purchase of Annuity**

I understand that if I do not qualify for the Life Insurance applied for above, the Company will issue an annuity contract under

Plan \_\_\_\_\_

Date \_\_\_\_\_ Signed at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Premium with Application \$ \_\_\_\_\_

Proposed Annuitant’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Owner’s Signature \_\_\_\_\_ Date \_\_\_\_\_

**Agent’s Statement**

I certify that I have correctly recorded in this Application, the information supplied by the Owner and/or Proposed Insured. To the best of my knowledge, replacement  is  is not involved in this transaction.

Agent’s Signature \_\_\_\_\_ Agent’s Number \_\_\_\_\_

Agent’s Name (please print) \_\_\_\_\_ Date \_\_\_\_\_

Signed at \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_

# Single Premium Whole Life – Last Survivor

1. Second Person Insured's Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 SS # \_\_\_\_\_ Place of Birth \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex  M  F  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Has the Second Insured used any form of tobacco or nicotine-based products in the last 12 months? .....  Yes  No
2. Has the Second Insured: Yes No
- a. Been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....
- b. Tested positive for antibodies to the AIDS virus or been advised not to give blood? .....
3. Has the Second Insured consulted a physician or been treated (including prescription medications) within the past five (5) years for:
- a. Cancer, leukemia or melanoma, systemic lupus, or has the Second Insured had more than one occurrence of cancer in his/her lifetime? .....
- b. Heart disease, heart surgery, stroke or any heart or circulatory disorder (except high blood pressure under control by medication)? .....
- c. Diabetes, kidney disease, liver disease or organ transplant? .....
- d. Emphysema or any other lung disorder requiring oxygen? .....
- e. Alzheimer's Disease, dementia, nervous disorder or mental disorder? .....
4. Is the Second Insured currently under treatment or taking prescription medication? .....
5. Has the Second Insured ever sought treatment for alcoholism or drug abuse? .....
6. Has the Second Insured had life or health insurance declined, non-renewed, rated, modified, postponed or cancelled?...
7. Is the Second Insured bedridden at home or confined to a hospital, nursing home or long-term care facility?.....

**Give complete details in the space provided below for all questions answered Yes. Attach separate sheet if necessary and be sure it is signed and dated.**

Question Number	Date(s) of Treatment	Provide reason(s) for consultation(s), names(s) and addresses and phone number(s) of physician(s) and include details of treatment prescribed, result(s) of consultation(s), and medication(s) prescribed.

8. Has the Second Insured engaged in or plan to engage in flying as a pilot, student, or crew member, underwater diving, hang gliding, ultralight flying, skydiving, parachuting, ballooning, bungee jumping or mountain or rock climbing?
9. Does the Second Insured currently have an application for insurance pending with any other company?    
 If Yes, please explain: \_\_\_\_\_
10. List life insurance and annuity policies in force on the life of the Second Insured:

Company	Policy Number	Year Issued	Plan	Amount	ADB Amount	Replaced

11. Beneficiary Designation for the Second Insured  
 The Primary Beneficiary or Beneficiaries who survive the Second Insured by 120 hours shall share equally unless otherwise indicated.
- A. Primary Beneficiary, address and relationship to Second Insured \_\_\_\_\_  
 \_\_\_\_\_
- B. Contingent Beneficiary, address and relationship to Second Insured \_\_\_\_\_  
 \_\_\_\_\_

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, Year \_\_\_\_\_

Witnessed by \_\_\_\_\_ **X** \_\_\_\_\_  
 Licensed Resident Agent Signature of Second Insured

Agency No. \_\_\_\_\_

**AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL INFORMATION**

Name of Proposed Insured ("Applicant") \_\_\_\_\_

I, on behalf of myself (or the minor child named above), 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, clearing house, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company"), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from 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 applicants residing in Maine or Vermont. **For residents of Maine, 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. 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 Proposed Insured IS NOT authorizing the Company to forward the results from any new test requested by the Company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.**)
- Information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.
- Information provided on my application 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 the Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Proposed Insured 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 Proposed Insured do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, clearing house or other health care provider to release and disclose the Proposed Insured'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. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company, 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 or policy reinstatement, and 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 the Company. 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, the Company may not be able to process this application.

\_\_\_\_\_  
Signature of Proposed Insured or Authorized Representative Date

\_\_\_\_\_  
Description of Authorized Representative or Relationship to Proposed Insured

**AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL MEDICAL INFORMATION**

Name of Proposed Insured ("Applicant") \_\_\_\_\_

I, on behalf of myself or the person named above ("Applicant"), 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, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company") or Assurity's Parent Company, its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Psychotherapy notes.

I understand that this information may be released by the Company or Parent Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Applicant 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 Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire psychotherapy notes 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 when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company or Parent Company and may no longer be protected by the federal rules governing privacy of health information.

This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by providing written notice to the Company or Parent Company. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Applicant to obtain treatment. I further understand that if I refuse to sign this authorization, Company or Parent Company may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

I acknowledge receipt of notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request.

**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 the law.**

Signature of Proposed Insured or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Description of Personal Representative's Authority or Relationship to Insured \_\_\_\_\_

**DESCRIPTION OF INFORMATION PRACTICES**  
including the notices required by the  
**Fair Credit Reporting Act and the Medical Information Bureau, Inc.**

This notice is a general description of the information practices followed by Assurity Life Insurance Company, ("Company"), Assurity's reinsurers, and by Your Assurity agent.

**NOTICE OF INVESTIGATIVE CONSUMER REPORT – Required by the Fair Credit Reporting Act**

In the course of properly underwriting and administering Your insurance coverage, We rely on the information You provide in Your application. We may also seek personal information about You from others, and/or obtain an investigative consumer report. This is customary in the business world, and part of the normal underwriting procedure. Investigative consumer reports typically include information about Your character, occupation, finances and mode of living, except as relates to sexual orientation. This information will be obtained through personal interviews with Your friends, neighbors and associates. You may write to Us and request further information about the nature and scope of the report. You may also elect to be interviewed in connection with the preparation of an investigative consumer report. You are entitled to request and receive a copy of any investigative consumer report.

**NOTICE OF ACQUISITION AND DISCLOSURE OF CONFIDENTIAL INFORMATION – Required by the Medical Information Bureau (MIB)**

Information regarding Your insurability will be treated as confidential. In some situations, and as allowed by law, We may disclose necessary items of information to third parties without Your specific authorization. We, as well as Our reinsurers, may make a brief report regarding Your insurability to Medical Information Bureau, Inc. ("MIB"). MIB is a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If You apply for life or health insurance coverage, or submit a claim for benefits to another MIB member company, that company may request and receive information in MIB's files.

You have a right to be told about, to see and to copy information about You contained in Our files. You also have the right to seek correction of information You believe to be inaccurate. MIB will also arrange disclosure of any information it may have in Your file upon receipt of Your request. If You question the accuracy of information in MIB's file, You may contact MIB at the address below and seek a correction according to the procedures set forth in the Fair Credit Reporting Act.

If You have questions after reading this notice, You may write to Us at the address below. We would be happy to provide a more detailed description of Our information practices. If You are already an Assurity Life Insurance Company policyholder or insured, Your individual policy number will help Us in assisting You.

**Company's Address**

Assurity Life Insurance Company  
Underwriting Department  
PO Box 82533  
Lincoln, Nebraska 68501-2533  
Toll-Free No. (800) 276-7619, Ext. 4264

**MIB'S Address**

Medical Information Bureau, Inc  
Information Office  
PO Box 105, Essex Station  
Boston, Massachusetts 02112  
Telephone No. (617) 426-3660

## CONDITIONAL RECEIPT

Please Read Carefully!

Received from \_\_\_\_\_ the sum of \$\_\_\_\_\_ paid with the attached Life Insurance Application to Assurity Life Insurance Company.

The Company agrees to insure the Proposed Insured if:

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

The terms of Conditional Insurance:

1. This Conditional Receipt is governed by the terms of the Policy applied for.
2. The total amount of life insurance in this Company, which may be effective on the life of the Proposed Insured, shall not exceed \$150,000 net amount at risk.
3. If the Proposed Insured dies before the policy is delivered to the Proposed Insured, the Company's sole obligation shall be to return the premiums paid to the estate of the Proposed Insured.
4. If a policy differing in form, amount or premium from that applied for is offered, no insurance shall be considered in effect under the application referred to herein unless and until the full premium is paid and a policy is immediately delivered to and accepted by the Proposed Insured.
5. This receipt is not transferable and will not be valid for any sum in excess of the sum set forth above. It will not be valid for any purpose if any alterations have been made in the printed form.
6. No agent or medical examiner has authority to waive the answer to any questions in the application, to pass on insurability, to waive any of the Company's rights or requirements or to make or alter any contract.
7. This receipt shall not be valid if any check or draft given for payment is not honored upon presentation.
8. This Conditional Receipt terminates 60 days after the Application date, or when the Policy applied for becomes effective, whichever occurs first.

Dated: \_\_\_\_\_ Agent: \_\_\_\_\_

**AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL INFORMATION**

Name of Proposed Insured ("Applicant") \_\_\_\_\_

I, on behalf of myself (or the minor child named above), 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, clearing house, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company"), its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from 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 applicants residing in Maine or Vermont. **For residents of Maine, 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. 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 Proposed Insured IS NOT authorizing the Company to forward the results from any new test requested by the Company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.**)
- Information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.
- Information provided on my application 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 the Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Proposed Insured 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 Proposed Insured do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, clearing house or other health care provider to release and disclose the Proposed Insured'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. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company, 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 or policy reinstatement, and 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 the Company. 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, the Company may not be able to process this application.

\_\_\_\_\_  
Signature of Proposed Insured or Authorized Representative Date

\_\_\_\_\_  
Description of Authorized Representative or Relationship to Proposed Insured

**AUTHORIZATION TO RELEASE AND USE CONFIDENTIAL MEDICAL INFORMATION**

Name of Proposed Insured ("Applicant") \_\_\_\_\_

I, on behalf of myself or the person named above ("Applicant"), 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, employer or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company") or Assurity's Parent Company, its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- Psychotherapy notes.

I understand that this information may be released by the Company or Parent Company and/or its reinsurers to their consulting physicians, their attorneys, MIB, and to other insurance companies in which the Applicant 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 Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire psychotherapy notes 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 when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company or Parent Company and may no longer be protected by the federal rules governing privacy of health information.

This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by providing written notice to the Company or Parent Company. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Applicant to obtain treatment. I further understand that if I refuse to sign this authorization, Company or Parent Company may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

I acknowledge receipt of notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request.

**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 the law.**

Signature of Proposed Insured or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Description of Personal Representative's Authority or Relationship to Insured \_\_\_\_\_

**ASSURITY LIFE INSURANCE COMPANY**

1526 K Street • PO Box 82533  
Lincoln, NE 68501-2533  
Phone: 800-869-0355 • Fax 402-437-4658

**Modified Endowment Contract Disclosure Statement**

The Technical and Miscellaneous Revenue Act of 1988 created a new class of life insurance contracts known as Modified Endowment Contracts. The principal purpose of this law was to restrict the use of life insurance as an investment. The law accomplished this by limiting the amount of premium that is allowed to be paid into a life insurance contract. The allowable amount of premium is dependent on the death benefit. If the calculated premium limits (defined in TAMRA 1988 code section 7702A) for a life insurance contract are exceeded, the life insurance contract becomes a Modified Endowment Contract.

The plan of insurance as illustrated for you exceeds the calculated allowable premium limits and would therefore be considered a Modified Endowment Contract. A policy that is a Modified Endowment Contract has the following implications for you:

- 1) Money distributed from a Modified Endowment Contract by cash distributions, withdrawals, loans, or assignments, will be considered taxable income until all gain, if any, has been distributed.
- 2) The taxable income amounts will also be subject to a 10% penalty tax unless you have attained age 59 1/2, become disabled, or you annuitize the entire cash value. (If the policy owner is a corporation, such proceeds are subject to the 10% penalty tax at any time).
- 3) Death benefits of Modified Endowment Contracts paid to any named beneficiary are treated as life insurance proceeds and therefore are not subject to income tax.

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

\_\_\_\_\_

Owner

\_\_\_\_\_

Date

\_\_\_\_\_

Agent

\_\_\_\_\_

Date

**ASSURITY LIFE INSURANCE COMPANY**

1526 K Street • P.O. Box 82533 • Lincoln, NE 68501-2533 • 800-869-0355

**TRANSFER/1035 EXCHANGE FORM**

Financial Institution Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Account/Policy Number: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Investment Vehicle: \_\_\_\_\_  
(CD, Mutual Fund, Life Insurance, Annuity, etc.)

Insured/Annuitant's name \_\_\_\_\_

Social security number \_\_\_\_\_

Owner's Name (complete if Insured is NOT the owner) \_\_\_\_\_

Social security number \_\_\_\_\_

**Contract Statement** (check one):  
 Contract attached.  Certificate of lost contract – I certify that the above-numbered contract has been lost or destroyed.

**Beneficiary Designation and Absolute Assignment to Effect Section 1035 Exchange of Annuity or Life Insurance Policy**

Please liquidate and transfer,  All  \$ \_\_\_\_\_  \_\_\_\_\_ %

of my account listed above to an Assurity Life Insurance Company Annuity. I am aware of and accept any surrender or withdrawal penalties that may be applied and request that proof of any such penalties be provided with the proceeds.

**Assignment statement:** I hereby assign all rights, title and interest in the above contract/policy, or the portion thereof indicated above if this is a partial exchange, with the above company to Assurity Life Insurance Company, in consideration of Assurity Life Insurance Company's agreement to issue its own contract on me. The new contract issued by Assurity will show a purchase payment equal to the value transferred to Assurity. I understand that if for any reason the existing insurance carrier issues a check for the original contract directly to me, I am obligated to endorse such check to Assurity only and to deliver such check to Assurity.

**Notice regarding partial 1035 exchanges and exchanges to existing contracts:** Partial exchanges with subsequent withdrawals or annuitizations may be subject to IRS challenge if entered into for the purpose of avoiding premature withdrawal or other penalties. Also, the Internal Revenue Service has not issued guidelines regarding the apportionment of basis between contracts involved in partial exchanges. Until such guidance is issued, Assurity will utilize a pro-rata formula for such apportionment. While Assurity believes this will be consistent with any IRS guidelines ultimately issued, these guidelines could mandate a different allocation method. Exchanges into existing contracts should be approached cautiously, and only after consultation with a tax advisor, since the IRS has not yet issued definitive guidance regarding the permissibility of such exchanges.

**Surrender direction:** This is intended to be a nontaxable exchange under Internal Revenue Code section 1035. By signing this form, I hereby direct the current institution to surrender my contract/policy (or to process a partial surrender or withdrawal if this is a partial exchange) and to transfer the proceeds directly to Assurity .

**Qualified and Non-Qualified Direct Custodial Transfer Request**

Type of Plan  
 Traditional IRA  SEP IRA  SIMPLE IRA  Roth IRA  401(k)  403(b)  QRP  Non-Qualified

**Authorization**

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 All  \$ \_\_\_\_\_  \_\_\_\_\_ %

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**Owner's Signature**

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

Signature of Joint Owner (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

Make check payable to: Assurity Life Insurance Company  
Assurity Contract No.: \_\_\_\_\_  
FBO: \_\_\_\_\_

Place signature guarantee here, if required

**Assurity Life Insurance Company Acceptance**

Assurity Life Insurance Company agrees to accept funds from the above Plan established for the above named individual and requests the liquidation and transfer of the assets indicated above.

By: \_\_\_\_\_  
Officer of the Company Title Date

**ASSURITY LIFE INSURANCE COMPANY**

1526 K Street • P.O. Box 82533 • Lincoln, NE 68501-2533 • 800-869-0355

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Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Account/Policy Number: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Investment Vehicle: \_\_\_\_\_  
(CD, Mutual Fund, Life Insurance, Annuity, etc.)

Insured/Annuitant's name \_\_\_\_\_

Social security number \_\_\_\_\_

Owner's Name (complete if Insured is NOT the owner) \_\_\_\_\_

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**Owner's Signature**

Signature of owner \_\_\_\_\_

Date \_\_\_\_\_

Signature of Joint Owner (if applicable) \_\_\_\_\_

Date \_\_\_\_\_

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By: \_\_\_\_\_  
Officer of the Company

Title

\_\_\_\_\_ Date

**Assurity Life Insurance Company**  
 1526 K Street • Box 82533  
 Lincoln, Nebraska 68501-2533  
 Telephone Toll-Free: (800) 276-7619, Ext. 4264

## **NOTICE REGARDING REPLACEMENT ASK QUESTIONS - IT'S YOUR MONEY - GET THE FACTS**

Whether it is to your advantage to replace or change your existing insurance or annuity program, only you can decide. It is in your best interest to obtain adequate information in order to compare relative short and long range costs and benefits before a final decision is made.

The agent or insurance company assisting you with this new purchase must notify your existing agent or company so that they may prepare a detailed, current statement concerning your existing program for your comparison.

### **EXISTING INSURANCE WHICH MAY BE REPLACED OR CHANGED**

FULL NAME OF INSURANCE COMPANY INCLUDING HOME OFFICE LOCATION	POLICY OR CONTRACT NUMBER*	INSURED

\*If a number has not been assigned by the existing insurer, indicate alternative identification, such as an application or receipt number.

### **ITEMS TO CONSIDER**

1. Due to a possible change in insurability status (health, occupation or high risk recreational activities) you might be denied new coverage, or the premium may be higher than a standard premium.
2. The Incontestability and Suicide Clause time periods would probably begin anew in a new policy. This could possibly result in a claim being denied that might otherwise have been paid under an existing policy or contract.
3. Your present insurance company may be able to modify your existing plan on terms, which may be more favorable for you than completely replacing it with a new policy or contract.
4. Don't terminate or alter your existing policy until after the new policy has been delivered to you and accepted by you.
5. **REMEMBER:** Following receipt of a new life insurance policy or annuity contract you should immediately examine its contents. If you are not satisfied with it for any reason, you have the right to return it within the twenty-day (20) "examination period" to Assurity at its home office or branch office or to the agent through whom it was purchased, for a full refund of premium. If you do return the policy or contract, you should request a dated receipt indicating that it was returned.

### **DID YOU READ THE "ITEMS TO CONSIDER"?**

Applicant's Signature	Date	Agent's Signature (if any)	Date
Applicant's Name (printed)		Agent's Name (printed) & License #	
Address		Address	
City, State, Zip Code		City State, Zip Code	
Telephone Number		Telephone Number	

**LIFE Repl-WY-99**

**Exhibit A**

**Signed form to be returned to Home Office  
 Applicant to receive a copy of signed form at time the application is taken**

**Assurity Life Insurance Company**  
 1526 K Street • Box 82533  
 Lincoln, Nebraska 68501-2533  
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Applicant's Signature	Date	Agent's Signature (if any)	Date
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Address		Address	
City, State, Zip Code		City State, Zip Code	
Telephone Number		Telephone Number	

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