Assurity

Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

Application for Individual Disability Insurance

PLEASE PRINT WITH BLACK INK

PRIMARY PROPOSED INSURED

Legal Name *First* *Middle* *Last*			Date of Birth *(MM/DD/YYYY)* / /
Social Security No.	☐ Male at Birth ☐ Female at Birth	E-mail	
Home Address *Street Address* *City* *State* *ZIP+4*			
Preferred Phone No. ( )	Birth State/Country	Height ft. in.	Weight lbs.
Driver's license state of issue:		Driver's license number:	

1. During the past **12 months**, has the Proposed Insured used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ☐ Yes ☐ No
2. During the past **12 months**, has the Proposed Insured used any form of marijuana or product containing THC? ☐ Yes ☐ No
3. Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident status? ☐ Yes ☐ No
   If the Proposed Insured has permanent resident status, please list the following:

   a. Green card number: _____

   b. Number of Years residing in the United States: _____

PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below.

What amount was collected with this application? $ _____

Type	Frequency
☐ Direct Billing ☐ Automatic Bank Withdrawal	☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ List Billing *(employer)*	☐ Monthly *(not available with Direct Billing)*

PRIMARY PROPOSED INSURED OCCUPATION INFORMATION

1. During the past six months, has the Proposed Insured been working continuously at least 30 hours per week, and are they currently working at least 30 hours per week? ☐ Yes ☐ No

2. During the past six months, has the Proposed Insured been limited in ability to perform regular occupational duties or work regular hours due to physical, mental or psychological impairment? ☐ Yes ☐ No

3. Is the Proposed Insured currently working as an employee, non-owner of any business? ☐ Yes ☐ No

If Yes, please provide details of all current sources of such earned income as follows:
(Gross income from this source is typically reported to IRS as W-2 income on Form 1040.)

Employer Name and Address	Job/Occupation	Duties	Years Employed	Weekly Hours Worked	Gross Annual Income

4. Is the Proposed Insured currently working as a sole proprietor or self-employed independent contractor? ☐ Yes ☐ No

If Yes, please provide details of all current sources of such earned income as follows:
(Net income from this source is typically reported to IRS via Form 1040, Schedule C.)

Job/Occupation	Duties	Years Self-Employed	Weekly Hours Worked	Percentage of hours worked from home	Net Annual Income

5. Is the Proposed Insured currently working for a business in which they have an ownership interest? ☐ Yes ☐ No

If Yes, please provide details of all current sources of such earned income as follows:
(Depending on the nature of the organization and type of income, typically reported as Form 1040, Schedule C income, Schedule E income, W-2 income; and/or Schedule K-1 income.)

Type of Business	Percentage Ownership	Years Owned	Job/Occupation	Duties	Percentage of hours worked from home	Net Annual Income, all types
☐ Partnership ☐ LLC ☐ C Corp ☐ S Corp ☐ Unknown ☐ Other (specify) _____						
☐ Partnership ☐ LLC ☐ C Corp ☐ S Corp ☐ Unknown ☐ Other (specify) _____						

6. Does the Proposed Insured have any unearned income (interest, dividends, net rental income, etc.)? ☐ Yes ☐ No

If YES, please provide total annual amount of all unearned income. _____

DISABILITY INCOME PRODUCT SECTION

Policy Type: ☑ Accident and Sickness Disability Income | Weekly Benefit Amount: $_____

Occupation Classes: ☐ 4A ☐ 3A ☐ 2A ☐ 1A

Please select your desired Maximum Benefit Period and Elimination Period.

☐ 13-Week Benefit Period:
Accident/Sickness Elimination Period Options: ☐ 0/7 days ☐ 0/14 days ☐ 7/7 days ☐ 14/14 days

☐ 26-Week Benefit Period:
Accident/Sickness Elimination Period Options: ☐ 0/7 days ☐ 0/14 days ☐ 7/7 days ☐ 14/14 days ☐ 30/30 days

☐ 1-Year Benefit Period:
Accident/Sickness Elimination Period Options: ☐ 0/7 days ☐ 0/14 days ☐ 7/7 days ☐ 14/14 days ☐ 30/30 days ☐ 60/60 days ☐ 90/90 days

☐ 2-Year Benefit Period:
Accident/Sickness Elimination Period Options: ☐ 30/30 days ☐ 60/60 days ☐ 90/90 days

ADDITIONAL BENEFITS *(If available)*

Check benefit(s) desired and indicate amount where requested.

☐ Catastrophic Disability Rider *(available with 1-Year or 2-Year benefit periods)* Weekly Benefit Amount: $_____

☐ Family Care Rider

☐ Guaranteed Insurability Rider

☐ Retroactive Injury Rider *(available with 30-day, 60-day, and 90-day elimination periods)*

☐ Return of Premium Rider

☐ Stay-at-Home Spouse Disability Income Rider* Weekly Benefit Amount: $_____

**Stay-at-Home Spouse must not be receiving retirement benefits, or working for wage, salary or profit.*

SPOUSE PROPOSED INSURED INFORMATION

Legal Name *First* *Middle* *Last*			Date of Birth *(MM/DD/YYYY)* / /
Social Security No.	☐ Male at Birth ☐ Female at Birth	E-mail	
Home Address *Street Address* *City* *State* *ZIP+4*			
Preferred Phone No. ( )	Birth State/Country	Height ft. in.	Weight lbs.
Driver's license state of issue:		Driver's license number:	

1. During the past **12 months**, has the Proposed Insured used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

2. During the past **12 months**, has the Proposed Insured used any form of marijuana or product containing THC? ..... ☐ Yes ☐ No

3. Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident status? ..... ☐ Yes ☐ No
   If the Proposed Insured has permanent resident status, please list the following:

   a. Green card number: _____

   b. Number of Years residing in the United States: _____

GENERAL SECTION FOR PRIMARY PROPOSED INSURED

Please answer the following questions.

1. Is the Proposed Insured currently or has the Proposed Insured entered into a written agreement to become a member of the military or an active duty member of the National Guard? ☐ Yes ☐ No

2. Does the Proposed Insured currently hold any type of pilot's license or intend to pursue a pilot's license within the **next 12 months**? ☐ Yes ☐ No

3. During the **past 12 months**, has the Proposed Insured engaged in, or does the Proposed Insured intend within the **next 12 months** to engage in, any of the following activities? Check all that apply.

   a. Motor sports events or racing (auto, truck, cycle, boat, etc.) ☐ Yes ☐ No

   b. Rock, mountain or ice climbing ☐ Yes ☐ No

   c. Skin or scuba diving ☐ Yes ☐ No

   d. Aeronautics (hang-gliding, sky diving, parachuting, ultralight soaring, ballooning, bungee jumping) ☐ Yes ☐ No

   e. Cave exploration ☐ Yes ☐ No

   f. Boxing ☐ Yes ☐ No

   g. Rodeo ☐ Yes ☐ No

   h. Professional, semi-professional sports ☐ Yes ☐ No

4. During the **past 12 months**, has the Proposed Insured traveled or lived outside of the United States, or does the Proposed Insured intend to travel or live outside the United States within the **next 12 months**? ☐ Yes ☐ No

5. During the **past 5 years**, has the Proposed Insured's driver's license been suspended or revoked; and/or has the Proposed Insured ever plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug; and/or has the Proposed Insured plead guilty or been convicted of more than 3 moving violations? ☐ Yes ☐ No

6. During the **past 10 years,** has the Proposed Insured plead guilty to or been convicted of a felony or misdemeanor? ☐ Yes ☐ No

7. Has the Proposed Insured **ever** filed for personal or business bankruptcy? ☐ Yes ☐ No

8. Is the Proposed Insured currently receiving any type of disability benefits or currently in the process of applying for any type of disability benefits, including social security or workers compensation? ☐ Yes ☐ No

9. Does the Proposed Insured have other disability income insurance coverage in force? ☐ Yes ☐ No

   If YES, please provide details for all in force coverage as follows.

Company Name	Individual or Group Coverage?	Employer Paid?	Monthly Benefit	Benefit Period	Is this coverage being replaced or modified?
	☐ Individual ☐ Group	☐ Yes ☐ No			☐ Yes ☐ No
	☐ Individual ☐ Group	☐ Yes ☐ No			☐ Yes ☐ No

GENERAL SECTION FOR SPOUSE PROPOSED INSURED

Please answer the following questions.

1. Is the Proposed Insured currently or has the Proposed Insured entered into a written agreement to become a member of the military or an active duty member of the National Guard? ☐ Yes ☐ No

2. Does the Proposed Insured currently hold any type of pilot's license or intend to pursue a pilot's license within the **next 12 months**? ☐ Yes ☐ No

3. During the **past 12 months**, has the Proposed Insured engaged in, or does the Proposed Insured intend within the **next 12 months** to engage in, any of the following activities? Check all that apply.

   a. Motor sports events or racing (auto, truck, cycle, boat, etc.) ☐ Yes ☐ No

   b. Rock, mountain or ice climbing ☐ Yes ☐ No

   c. Skin or scuba diving ☐ Yes ☐ No

   d. Aeronautics (hang-gliding, sky diving, parachuting, ultralight soaring, ballooning, bungee jumping) ☐ Yes ☐ No

   e. Cave exploration ☐ Yes ☐ No

   f. Boxing ☐ Yes ☐ No

   g. Rodeo ☐ Yes ☐ No

   h. Professional, semi-professional sports ☐ Yes ☐ No

4. During the **past 12 months**, has the Proposed Insured traveled or lived outside of the United States, or does the Proposed Insured intend to travel or live outside the United States within the **next 12 months**? ☐ Yes ☐ No

5. During the **past 5 years**, has the Proposed Insured's driver's license been suspended or revoked; and/or has the Proposed Insured ever plead guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug; and/or has the Proposed Insured plead guilty or been convicted of more than 3 moving violations? ☐ Yes ☐ No

6. During the **past 10 years**, has the Proposed Insured plead guilty to or been convicted of a felony or misdemeanor? ☐ Yes ☐ No

7. Has the Proposed Insured **ever** filed for personal or business bankruptcy? ☐ Yes ☐ No

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   If YES, please provide details for all in force coverage as follows.

Company Name	Individual or Group Coverage?	Employer Paid?	Monthly Benefit	Benefit Period	Is this coverage being replaced or modified?
	☐ Individual ☐ Group	☐ Yes ☐ No			☐ Yes ☐ No
	☐ Individual ☐ Group	☐ Yes ☐ No			☐ Yes ☐ No

HEALTH SECTION FOR PRIMARY PROPOSED INSURED

Please answer the following questions.

1. During the past **10 years**, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any of the following: Alzheimer's Disease, Insulin dependent Diabetes, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Cirrhosis of the liver, Polycystic Kidney Disease, Hemophilia requiring replacement therapy, Personality disorders, Psychotic disorders or Schizophrenia, Myasthenia Gravis, Human Immunodeficiency Virus (HIV virus) or Acquired Immune Deficiency Syndrome (AIDS), Guillain-Barre Syndrome, or organ transplant of any type? ☐ Yes ☐ No

2. During the past **10 years**, has the Proposed Insured been diagnosed, treated for, or been given medical advice by a member of the medical profession for non-insulin dependent Diabetes? ☐ Yes ☐ No

3. During the past **10 years**, has the Proposed Insured:
   a. Used narcotics, opioids, benzodiazepines, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit-forming drugs, except as prescribed by a physician? ☐ Yes ☐ No
   b. Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No

4. During the past **10 years**, has the Proposed Insured needed assistance or supervision to perform any activities of daily living (toileting, transferring, continence, eating, bathing or dressing)? ☐ Yes ☐ No

5. During the past **10 years**, has the Proposed Insured been diagnosed, treated, or been given medical advice by a member of the medical profession for heart attack, heart disease, angina, uncontrolled hypertension, chronic lung disease, mental/nervous disease or disorder, stroke or any type of internal cancer or melanoma (not including basal or squamous cell carcinoma of the skin), or disease/ disorder of the stomach, intestine, bowel or rectum? ☐ Yes ☐ No

6. During the past **12 months**, has the Proposed Insured been diagnosed, treated, or been given medical advice by a member of the medical profession for any disease or disorder of the spine, bones, joints or muscles? ☐ Yes ☐ No

7. During the past **6 months**, has the Proposed Insured been hospitalized for any infectious diseases, including COVID-19 (Coronavirus), Ebola, MRSA (Methicillin-Resistant Staphylococcus Aureus), SARS (Severe Acute Respiratory Syndrome), MERS (Middle East Respiratory Syndrome), Zika? ☐ Yes ☐ No

8. In the next **6 months**, is the Proposed Insured scheduled to have surgery or other medical procedure, or has the Proposed Insured been advised by a member of the medical profession to have surgery or other medical procedure? ☐ Yes ☐ No

9. During the past **12 months**, has the Proposed Insured been advised by a member of the medical profession to have diagnostic/screening tests that have not been completed, or for which results have not been received? ☐ Yes ☐ No

10. Is the Proposed Insured currently pregnant? ☐ Yes ☐ No

HEALTH SECTION FOR SPOUSE PROPOSED INSURED

Please answer the following questions.

1. During the past **10 years**, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for any of the following: Alzheimer's Disease, Insulin dependent Diabetes, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Cirrhosis of the liver, Polycystic Kidney Disease, Hemophilia requiring replacement therapy, Personality disorders, Psychotic disorders or Schizophrenia, Myasthenia Gravis, Human Immunodeficiency Virus (HIV virus) or Acquired Immune Deficiency Syndrome (AIDS), Guillain-Barre Syndrome, or organ transplant of any type? ☐ Yes ☐ No

2. During the past **10 years**, has the Proposed Insured been diagnosed, treated for, or been given medical advice by a member of the medical profession for non-insulin dependent Diabetes? ☐ Yes ☐ No

3. During the past **10 years**, has the Proposed Insured:
   a. Used narcotics, opioids, benzodiazepines, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit- forming drugs, except as prescribed by a physician? ☐ Yes ☐ No
   b. Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ☐ Yes ☐ No

4. During the past **10 years**, has the Proposed Insured needed assistance or supervision to perform any activities of daily living (toileting, transferring, continence, eating, bathing or dressing)? ☐ Yes ☐ No

5. During the past **10 years**, has the Proposed Insured been diagnosed, treated, or been given medical advice by a member of the medical profession for heart attack, heart disease, angina, uncontrolled hypertension, chronic lung disease, mental/nervous disease or disorder, stroke or any type of internal cancer or melanoma (not including basal or squamous cell carcinoma of the skin), or disease/ disorder of the stomach, intestine, bowel or rectum? ☐ Yes ☐ No

6. During the past **12 months**, has the Proposed Insured been diagnosed, treated, or been given medical advice by a member of the medical profession for any disease or disorder of the spine, bones, joints or muscles? ☐ Yes ☐ No

7. During the past **6 months**, has the Proposed Insured been hospitalized for any infectious diseases, including COVID-19 (Coronavirus), Ebola, MRSA (Methicillin-Resistant Staphylococcus Aureus), SARS (Severe Acute Respiratory Syndrome), MERS (Middle East Respiratory Syndrome), Zika? ☐ Yes ☐ No

8. In the next **6 months**, is the Proposed Insured scheduled to have surgery or other medical procedure, or has the Proposed Insured been advised by a member of the medical profession to have surgery or other medical procedure? ☐ Yes ☐ No

9. During the past **12 months**, has the Proposed Insured been advised by a member of the medical profession to have diagnostic/screening tests that have not been completed, or for which results have not been received? ☐ Yes ☐ No

10. Is the Proposed Insured currently pregnant? ☐ Yes ☐ No

AGREEMENT

I (We) agree that:

a. All answers in this application are complete and true to the best of my (our) knowledge and belief and will be relied upon to determine insurability.

b. If the 13-week benefit period has been selected, I (we) am (are) aware of and understand the limited duration of this benefit period.

c. The first premium is equal to the full premium for the premium payment mode selected. If the first premium is paid on the date this application is signed, the insurance applied for becomes effective on that date subject to: a) the Company's underwriting requirements, b) the terms of the attached Temporary Conditional Insurance Agreement, and c) the terms of the policy applied for.

d. If the first premium is not paid on the date of this application, no insurance will be in effect unless: a) the application is approved by the Company, b) such policy is issued, delivered to and accepted by me (us), c) the entire first premium is paid during the Proposed Insured's lifetime, and d) at the time of such delivery, acceptance or payment, whichever is later, all information furnished in this application remains true and complete to the best of my (our) knowledge.

e. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement, or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Substitute Form W-9 information (Request for Taxpayer Identification Number and Certification): I certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed in _____ on ____/____/____

State *Date (MM/DD/YYYY)*

_____ _____

Signature of Primary Proposed Insured *Signature of Spouse Proposed Insured*

_____ _____

Signature of Licensed Agent *Print Agent Name and Agent No.*

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Confidential Information Authorization

_____ _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth (MM/DD/YYYY)***

_____ _____
Legal Name of Additional Applicant/Insured/Claimant (Please print) ***Date of Birth (MM/DD/YYYY)***

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name	***Date of Birth***	*Legal Name*	***Date of Birth***

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB LLC, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- 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.
- 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 sessions *(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.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB LLC and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB LLC.

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, MIB LLC, 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 redisclosure 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.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

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

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

Assurity®

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Confidential Information Authorization for Release of Psychotherapy Notes

_____ _____
Legal Name of Applicant/Insured/Claimant (Please print) ***Date of Birth (MM/DD/YYYY)***

Legal Name of Additional Applicant/Insured/Claimant (Please print) ***Date of Birth (MM/DD/YYYY)***

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

Legal Name	***Date of Birth***	*Legal Name*	***Date of Birth***

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB LLC, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- Psychotherapy notes

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB LLC and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB LLC.

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, MIB LLC, 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 redisclosure 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.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twelve *(12)* 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 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)

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CONSUMER NOTICE

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, LLC, which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 or go to its website at www.mib.com to request a disclosure online. If you question the accuracy of the information in MIB's file, you may contact MIB and 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, Suite 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 website at www.mib.com.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, Assurity will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices, please direct your requests to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended *(15 U.S.C. 1681d)*, notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, Assurity Life Insurance Company *(Assurity)* may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation Assurity requests. Please direct this written request to Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533.

Upon receipt of such a request, Assurity will respond by mail within five business days.

Telephone Interview Information

Assurity may require that you complete a confidential telephone interview as a part of your application for insurance. The interview will be conducted by a trained professional and may include *(but is not limited to)* the following topics: occupation, job history, income, personal and business financial information and medical history. All information obtained will be used for underwriting purposes only and will not be released without your written consent.

How to Submit Your Application

- **Phone / Agent Assisted (recommended).** Provide information over the phone, then wait for your link from the carrier to e-sign the fully prepared application.
- **Fax:** (206) 899 1356. This is Rip's direct fax number. No cover is necessary.
- **Upload:** https://disabilityunderwriters.com/upload
- **DocuSign:** Request a DocuSign version.
- **Email:** rip@ripcurtis.com. Do not use ordinary email. If you don't know how to send securely, please ask.

Receipt will be acknowledged promptly.

Rip W. Curtis
Disability Underwriters
1420 5th Avenue, Suite 2200
Seattle, WA 98101
(206) 652 2266

State insurance license numbers

Alabama 693034
Alaska 0109096
Arkansas 670169
Arizona 1034318
California 0B73499
Colorado 351718
Connecticut 2625242
Delaware 3000471370
District of Columbia 3000085210
Florida W004391
Georgia 3009530
Hawaii 486346
Idaho 292989
Illinois 670169
Indiana 3411220
Iowa 670169
Kansas 670169
Kentucky 1026779
Louisiana 727692
Maine PRN325152
Maryland 3000002183
Massachusetts 1932470
Montana 3000276492
Michigan 0721730
Minnesota 40519161
Mississippi 10594113
Missouri 8345962
Nebraska 0670169
Nevada 3157202
New Hampshire 670169
New Jersey 1576772
New Mexico 670169
New York 1484281
North Carolina 0670169
North Dakota 670169
Ohio 769705
Oklahoma 3000471388
Oregon 670169
Pennsylvania 847459
Rhode Is. 3000471373
South Carolina 670169
South Dakota 40507150
Tennessee 2047645
Texas 1726888
Utah 483697
Vermont 3411471
Virginia 895401
Washington 118074
West Virginia 670169
Wisconsin 2635185
Wyoming 391239