Would you like

on your submitted applications?

Assurity Life Insurance Company is working with you to get your business underwritten and issued as fast as possible. This will put the policy in your client's hand, and commissions in your pocket!

While several items have an impact on your business, you can speed the process by filling out the application completely and correctly. Some helpful steps are outlined in this brochure.

Please take the time to write carefully. Double-check all answers and complete all questions.

You can gain faster access to applications, product information, commissions, pending status, and forms by checking our agent-only Web site: https://assurelink.assurity.com.

Step 1 — **Application.** Print clearly.

The combined app is state-specific. Any changes, additions, or deletions will require an Amendment of Application form to be signed at delivery. Underwriting cannot adjust information on the application. Any changes made during the application process must be initiated by the Applicant. The use of white correction fluid or tape is not acceptable. Print clearly, as any unreadable information will slow the underwriting process.

Fill in all basic information on your client.

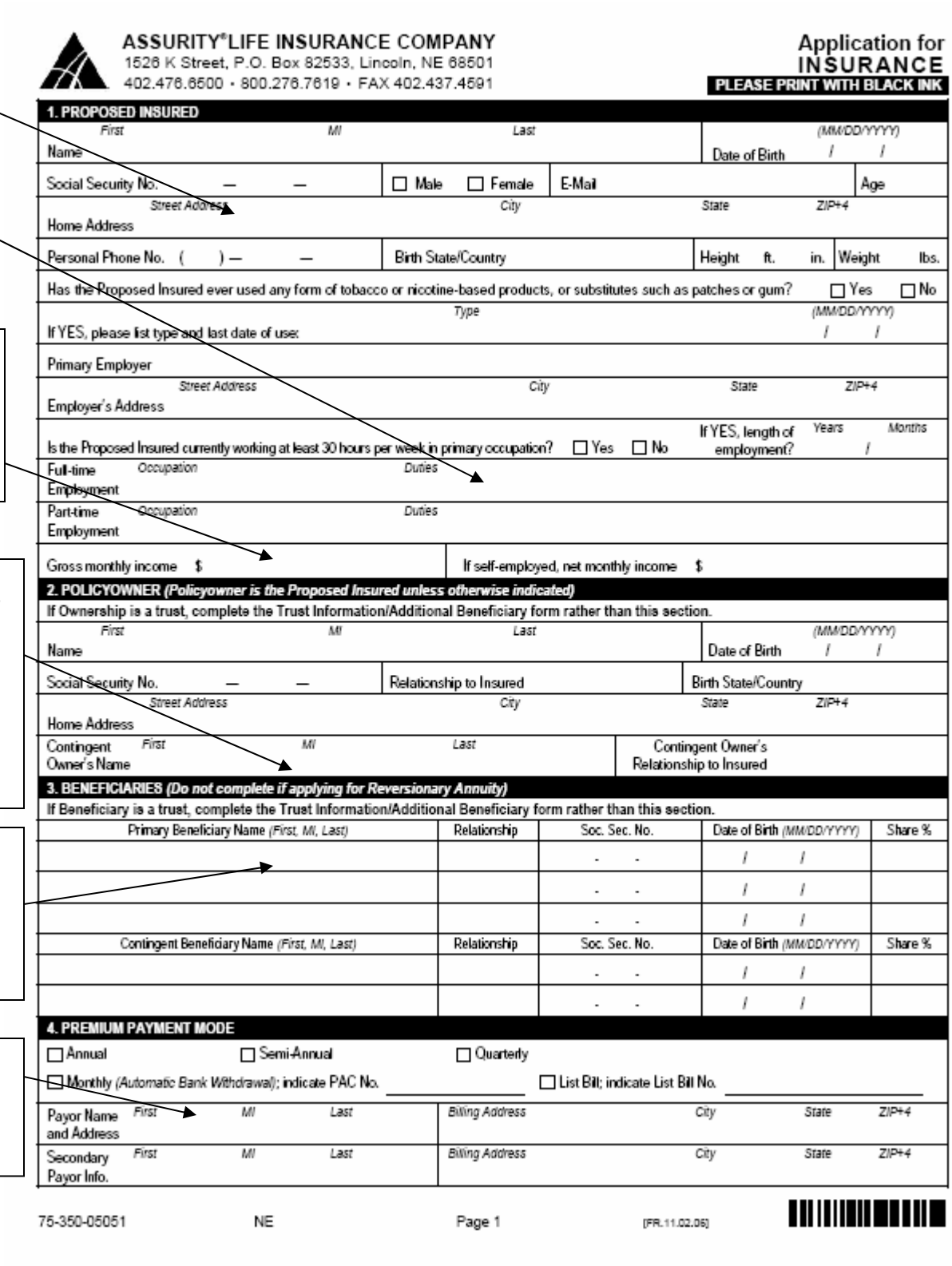
Include job **duties** not just a job **title.**

Note the difference between W-2 – **gross income** and Self-Employed – **net income** after expenses.

Fill in all information on the policy owner. Owner is usually the insured; if not; owner must have insurable interest in the insured, such as immediate family member or business partner.

Enter all information on the beneficiary. If there are more then room allows, continue on Additional Beneficiary Page.

Fill in all information on payor. If Monthly PAC, enter payor's bank info on Field Underwriter's Statement.



ASSURITY® LIFE INSURANCE COMPANY
1526 K Street, P.O. Box 82533, Lincoln, NE 68501
402.476.6500 • 800.276.7619 • FAX 402.437.4591

Application for INSURANCE
PLEASE PRINT WITH BLACK INK

1. PROPOSED INSURED

Name (First, MI, Last) — Date of Birth (MM/DD/YYYY)

Social Security No. — — ☐ Male ☐ Female — E-Mail — Age

Home Address (Street Address, City, State, ZIP+4)

Personal Phone No. ( ) — — — Birth State/Country — Height ft. in. — Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ☐ Yes ☐ No

If YES, please list type and last date of use: Type — (MM/DD/YYYY)

Primary Employer

Employer's Address (Street Address, City, State, ZIP+4)

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No — If YES, length of employment? Years Months

Full-time Employment — Occupation — Duties

Part-time Employment — Occupation — Duties

Gross monthly income $ — If self-employed, net monthly income $

2. POLICYOWNER ***(Policyowner is the Proposed Insured unless otherwise indicated)***

If Ownership is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

Name (First, MI, Last) — Date of Birth (MM/DD/YYYY)

Social Security No. — — Relationship to Insured — Birth State/Country

Home Address (Street Address, City, State, ZIP+4)

Contingent Owner's Name (First, MI, Last) — Contingent Owner's Relationship to Insured

3. BENEFICIARIES ***(Do not complete if applying for Reversionary Annuity)***

If Beneficiary is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

Primary Beneficiary Name (First, MI, Last)	Relationship	Soc. Sec. No.	Date of Birth (MM/DD/YYYY)	Share %
		- -	/ /	
		- -	/ /	
		- -	/ /	
Contingent Beneficiary Name (First, MI, Last)	**Relationship**	**Soc. Sec. No.**	**Date of Birth (MM/DD/YYYY)**	**Share %**
		- -	/ /	
		- -	/ /	

4. PREMIUM PAYMENT MODE

☐ Annual ☐ Semi-Annual ☐ Quarterly

☐ Monthly (Automatic Bank Withdrawal); indicate PAC No. _____ ☐ List Bill; indicate List Bill No. _____

Payor Name and Address (First, MI, Last) — Billing Address — City — State — ZIP+4

Secondary Payor Info. (First, MI, Last) — Billing Address — City — State — ZIP+4

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Step 1 Application, page 2
If no Joint-Insured, this page does not need to be sent to the company.

Fill in all information on any person to be insured on a rider to the primary policy. If none, leave blank.

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Application for INSURANCE
PLEASE PRINT WITH BLACK INK

5. PROPOSED JOINT-INSURED

Name (First, MI, Last) | Date of Birth (MM/DD/YYYY) / /

Social Security No. — — | ☐ Male ☐ Female | E-Mail | Age

Home Address (Street Address, City, State, ZIP+4)

Personal Phone No. ( ) — — | Birth State/Country | Height ft. in. | Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ☐ Yes ☐ No

If YES, please list type and last date of use: (Type) (MM/DD/YYYY) / /

Primary Employer

Employer's Address (Street Address, City, State, ZIP+4)

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No | If YES, length of employment? Years Months /

Full-time Employment (Occupation, Duties)

Part-time Employment (Occupation, Duties)

Gross monthly income $ | If self-employed, net monthly income $

Step 2 – Additional Beneficiary. If no information is filled in, this page does not need to be sent in with the application.

Reenter primary applicant info.

Continue the list of beneficiaries if more than space provided on the first page. Be sure to include % of share.

TRUST INFORMATION/ADDITIONAL BENEFICIARY

Please complete the following sections if Ownership and/or Beneficiary is a trust *(or if additional room is needed to list beneficiaries of Policy)*:

1. POLICYOWNER ***(Policyowner is the Proposed Insured unless otherwise indicated)***

Name *First*	*MI*	*Last*	Date of Birth *(MM/DD/YYYY)* / /
Social Security No. — —			Relationship to Insured
Home Address *Street Address*		*City*	*State* *ZIP+4*
Contingent Owner's Name *First*	*MI*	*Last*	Contingent Owner's Relationship to Insured

2. BENEFICIARIES ***(Do not complete if applying for Reversionary Annuity)***

Primary Beneficiary Name *(First, MI, Last)*	Relationship	Soc. Sec. No.	Date of Birth *(MM/DD/YYYY)*	Share %
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	

Contingent Beneficiary Name *(First, MI, Last)*	Relationship	Soc. Sec. No.	Date of Birth *(MM/DD/YYYY)*	Share %
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	
☐ Testamentary Trust *(Will)*	N/A	N/A	N/A	
☐ Living Trust *(Please complete section below.)*	N/A	N/A	N/A	

Name of Living Trust _____

Date of Trust *(MM/DD/YYYY)* / / Tax ID No. of Trust _____

Name of Trustee(s) _____

Address of Trustee(s) _____

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Step 3 – General Section. All questions must be answered "yes" or "no."

Q2: If "yes," include Avocation Questionnaire. This form can be found on the Assurity extranet site.

If "yes" to any questions, explain on the line provided. If you need more space, attach another piece of paper. Do not write on the back of this form.

Q9: Provide all information, whether coverage is group or individual.

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or Military? ☐ Yes ☐ No
   If YES, please explain: _____

2. During the past 5 years or within the next 12 months: *(If YES to any of the following, please complete and return the Avocation Questionnaire.)*
   a. Has any Proposed Insured flown, or is any Proposed Insured planning to fly, as a pilot, crew member or student? ☐ Yes ☐ No
   b. Has any Proposed Insured participated in, or is any Proposed Insured planning to participate in any hazardous sport or activities? ☐ Yes ☐ No
   (If Yes, check all that apply.) ☐ Skin/Scuba Diving ☐ Mountain Climbing ☐ Skydiving/Parachuting/Hang Gliding ☐ Motor-powered Racing ☐ Boxing ☐ Professional, Semi-professional or Club Sports

3. During the next 12 months, does any Proposed Insured contemplate residence or travel outside of the U.S.A.? ☐ Yes ☐ No
   If YES, please explain: _____

4. During the past 5 years, has any Proposed Insured:
   a. Had a life, health or hospital expense insurance application postponed, rated up, ridered or declined, or had insurance renewal or reinstatement refused? ☐ Yes ☐ No
   If YES, please explain: _____
   b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ Yes ☐ No
   If YES, please explain: _____

5. Is any Proposed Insured negotiating for other insurance coverage? ☐ Yes ☐ No
   If YES, please explain: _____

6. During the past 5 years, has any Proposed Insured:
   a. Received any citations for motor vehicle moving violations or had a driver's license suspended or revoked? ☐ Yes ☐ No
   If YES, please explain: _____
   b. Had 2 or more traffic accidents or been convicted of driving under the influence of alcohol or drugs? ☐ Yes ☐ No
   If YES, please explain: _____

7. During the past 12 months, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No
   (If YES, please list Proposed Insured's name, amount of weight change and reason for change.)
   _____

8. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
   (If YES, please complete and return the appropriate State Replacement Form.)

9. Does any Proposed Insured have other insurance coverage in force? *(If YES, please provide details below.)* ☐ Yes ☐ No

Company Name	Policy No.	Business *(B)* Personal *(P)*	Benefits *(monthly benefit and benefit period for DI or face amount for Life)*	Issue Date *(MM/DD/YYYY)*	DI Coverage Only: Coordinated w/ Soc. Sec.?	DI Coverage Only: Employer Paid?
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No

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Step 4 – Health Section

Note: Qs 1, 2, & 3 refer to:
Have they **EVER**.

Any details from Qs 1-6 are to be entered in the space in #7.

Provide all info on the medical provider for each incidence.

HEALTH SECTION

Please answer the following questions. *(If YES to any of the following, please provide details in #7 below.)*

1. Has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following:
   - a. Dizziness, fainting spells, epilepsy, depression, attempted suicide, anxiety, mental disorder, or any disease or disorder of the brain or nervous system? ☐ Yes ☐ No
   - b. Asthma, bronchitis, tuberculosis, pneumocystis or any disorder of the lungs or respiratory system? ☐ Yes ☐ No
   - c. High blood pressure, chest pain, shortness of breath, heart murmur, rheumatic fever, hemophilia, coagulation or blood disorder or any disease or disorder of the heart or blood vessel? ☐ Yes ☐ No
   - d. Any disease or disorder of the stomach, intestines, bowel, rectum, appendix, liver, thyroid or gall bladder? ☐ Yes ☐ No
   - e. Any disease or disorder of the kidney, bladder or prostate? ☐ Yes ☐ No
   - f. Arthritis, rheumatism, or any disease or disorder of the back, spine, bones, joints or muscles? ☐ Yes ☐ No
   - g. Diabetes, or sugar, albumin or blood in the urine? ☐ Yes ☐ No
   - h. Cancer or a tumor or cyst of any kind, or enlargement of lymph nodes? ☐ Yes ☐ No
   - i. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? ☐ Yes ☐ No
   - j. Any disease or disorder of the eyes, ears, nose or throat? ☐ Yes ☐ No
   - k. Alcoholism, drug addiction, drug abuse, other substance abuse, or sought advice or treatment for such? ☐ Yes ☐ No
   - l. Any other illness or injury requiring medical attention or blood transfusions? ☐ Yes ☐ No
2. Has any Proposed Insured ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome *(AIDS)*, AIDS-Related Complex *(ARC)* or Antibodies to Human T-lymphotropic Virus Type III *(HTLV)*; or had a positive test for Human Immunodeficiency Virus *(HIV)* antibodies? ☐ Yes ☐ No
3. Has any Proposed Insured ever needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing or dressing)*? ☐ Yes ☐ No
4. Has any immediate family member *(parents, brothers or sisters)* of any Proposed Insured died from cancer, diabetes, or blood vessel, kidney or cardiovascular disease prior to age 60? *(If YES, please identify family member, relationship to proposed insured, disorder and age at death.)* ☐ Yes ☐ No

   _____
5. a. Has any Proposed Insured ever had any disorder of any genital or reproductive organ, or a miscarriage, stillbirth or Caesarean section? ☐ Yes ☐ No

   b. Is any Proposed Insured now pregnant? *(If YES, date child is expected* MM / DD / YYYY _____*)* ☐ Yes ☐ No
6. During the past 5 years, has any Proposed Insured had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests *(other than AIDS-related blood tests)* or urine tests? ☐ Yes ☐ No
7. DETAILS: Enter complete details from questions #1-6 below. *(If additional space is needed, attach Supplemental Information form.)*

Question #/Letter	Name *(First, MI Last)*	Relationship to Insured	Date of Condition *(MM/DD/YYYY)*	Health Condition & Details	Medical Care Provider's Name/Address/Phone
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		

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16-201-00001 (7/07)

Step 4 – Health Section, Page 2. This page must be included with the application, whether or not you have entered any information.

SUPPLEMENTAL INFORMATION

Question #/Letter	Name *(First, MI Last)*	Relationship to Insured	Date of Condition *(MM/DD/YYYY)*	Health Condition & Details	Medical Care Provider's Name/Address/Phone
			/ /		
			/ /		
			/ /		
			/ /		
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Any additional information for the underwriter can be entered here.

Additional Information:

Home Office Use Only

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Step 5 – Life Product

Choose which life product you are applying for.

Lesser of $3,000 or 1.5% of base policy, and not more than 60% of their income.

1 unit ($1,000) for every $5,000 of face amount.

Refers to Level or Decreasing Benefit.

Fill in all information on each additional person. Maximum is one spouse and 4 children

Only **1** rider per Additional Person per policy.

LIFE PRODUCT SECTION

Plan of Insurance: *(Check one)* ☐ Term Life ☐ Whole Life ☐ Other *(Please specify)* _____

Specify Plan *(Name)* _____

Base Amount $ _____ Number of years for term policy: ☐ 10 Year ☐ 15 Year ☐ 20 Year

If cash value is available, should the Automatic Premium Loan provision be made effective? ☐ Yes ☐ No

Dividend Option: ☐ Paid-Up Additions ☐ Accumulate at Interest ☐ Reduce Premiums ☐ Paid in Cash

ADDITIONAL BENEFITS *(If available)*

Available on Term Life and Whole Life. Check benefit(s) desired and indicate amount requested.

☐ Waiver of Premium Rider ☐ Children's Term Insurance Rider _____ units

☐ Monthly Disability Income Rider $ _____ ☐ Other *(Please specify)* _____ $ _____

☐ Accident Only DI Rider $ _____ ☐ Other *(Please specify)* _____ $ _____

☐ Payor Benefit Rider *(Complete Health Section for Payor)* Payor Name _____ DOB ___/___/___ ☐ M ☐ F

Available on Whole Life. Check benefit(s) desired and indicate amount requested.

☐ YRT Rider $ _____ ☐ Level ☐ Decreasing

☐ Protected Insurability Rider _____ units

☐ Accidental Death Benefit Rider $ _____

☐ Paid-up Additions Rider *(VER)* $ _____ ☐ Periodic Premiums $ _____ ☐ Single Premium $ _____

☐ Decreasing Term Rider $ _____ ☐ 10 Year ☐ 15 Year ☐ 20 Year ☐ 25 Year ☐ 30 Year

☐ Additional Person Term Rider(s) – Please complete the information below.

Information	Additional Ins./Child Rider No. 1	Additional Ins./Child Rider No. 2	Additional Ins./Child Rider No. 3
Name *(First, MI, Last)*			
Face Amount/Units *(Child Rider)*	$ /	$ /	$ /
Level/Decreasing	☐ Level ☐ Decrease	☐ Level ☐ Decrease	☐ Level ☐ Decrease
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /
Age			
Social Security No.	– –	– –	– –
Birth State/Country			
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Relationship to Insured			
Employer			
Occupation			
Gross monthly income	$	$	$
If self-employed, net mo. income	$	$	$
Additional Person Riders:			
Select rider—	☐ Monthly Disability Income ☐ Accident Only Disability Income	☐ Monthly Disability Income ☐ Accident Only Disability Income	☐ Monthly Disability Income ☐ Accident Only Disability Income
Monthly benefit amount	$	$	$

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Step 6 – Universal Life

Choose from the Premier, Select, or Survivor

Indicate special date options; i.e., to save age. Can be up to 6 months prior to the app date.

If Additional Insured or Child Term Rider is chosen, complete all information on each person.

UNIVERSAL LIFE PRODUCT SECTION

Plan of Insurance *(Specify UL Plan Name)*: _____

Base Amount $ _____ Special Policy Date *(If desired)* _____

Planned periodic premium $ _____ Amount of Insurance is Face Amount unless shown differently here: ☐ Face + Accumulated Value

ADDITIONAL BENEFITS

Check benefit(s) desired and indicate amount requested.

☐ Disability Waiver

Available to ages 0-60. Terminates at age 65.

☐ GAP *(Guaranteed Additional Purchase)* $ _____

☐ ADB *(Accidental Death Benefit)* $ _____

☐ 10-year Term Rider $ _____

☐ 20-year Term Rider $ _____

☐ 10-year Additional Insured/Spouse Rider $ _____

☐ 10-year Additional Insured/Spouse Rider $ _____

☐ Children's Term Rider _____ units $ _____

☐ Other *(Please specify)* _____ $ _____

☐ Other *(Please specify)* _____ $ _____

Information	Additional Ins./Child Rider No. 1	Additional Ins./Child Rider No. 2	Additional Ins./Child Rider No. 3
Name *(First, MI, Last)*			
Face Amount/Units *(Child Rider)*	$ /	$ /	$ /
Date of Birth *(MM/DD/YYYY)*	/ /	/ /	/ /
Age			
Social Security No.	– –	– –	– –
Birth State/Country			
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Height/Weight	ft. in. / lbs.	ft. in. / lbs.	ft. in. / lbs.
Relationship to Insured			
Employer			
Occupation			
Gross monthly income	$	$	$
If self-employed, net mo. income	$	$	$

75-357-05051 NE [FR.11.02.06]

Step 7 Critical Illness. Both CI pages must be submitted with the application.

$50,000 thru $50,0000

CTIR- either $5,000 or $10,000. Cannot exceed primary base

Provide all information for each additional insured.

CRITICAL ILLNESS PRODUCT SECTION

Plan of Insurance: *(Check one)* ☐ Critical Illness ☐ Other *(Please specify)* ______________

Base Amount $ ______________

ADDITIONAL BENEFITS *(If available)*

Check benefit(s) desired and indicate amount requested.

☐ Accidental Death Benefit Rider $ ______________ ☐ Children's Term Insurance Rider ______________ units

☐ Waiver of Premium Rider ☐ Other *(Please specify)* ______________ $ ______________

☐ Spouse Rider $ ______________ ☐ Other *(Please specify)* ______________ $ ______________

☐ Additional Insured Rider(s) — Please complete the information below. *(If additional space is needed, attach a separate sheet of paper.)*

Additional Insured — Spouse

Name *First* *MI* *Last*				☐ Male ☐ Female
Social Security No. — —	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /	
Primary Employer			Height ft. in.	Weight lbs.

Additional Insured — Child

Name *First* *MI* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No. — —	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured — Child

Name *First* *MI* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No. — —	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured — Child

Name *First* *MI* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No. — —	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured — Child

Name *First* *MI* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No. — —	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured — Child

Name *First* *MI* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No. — —	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Additional Insured — Child

Name *First* *MI* *Last*	☐ Male ☐ Female	Height ft. in.	Weight lbs.
Social Security No. — —	Birth State/Country	Age	Date of Birth *(MM/DD/YYYY)* / /

Step 7 – Critical Illness, page 2

CRITICAL ILLNESS HEALTH SECTION

Please answer the following questions. *(If YES to any of the following, please provide details in #7 below.)*

1. Has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following:
   a. Heart attack, stroke, elevated or abnormal cholesterol, angina, coronary heart disease, disease of the blood vessels or TIA *(Transient Ischemic Attack)*? ☐ Yes ☐ No
   b. Thyroid disorder, hepatitis, hepatitis carrier, anemia, fatigue, disorder of the pancreas, any lupus or any other blood or glandular disorder? ☐ Yes ☐ No
   c. Polyp, mole, lump, other growth, breast disorder or abnormal mammogram, biopsy or abnormal Prostate Specific Antigen *(PSA)* test? ☐ Yes ☐ No
2. Does any Proposed Insured regularly take any prescription medications? *(If YES, specify type and daily dosage in #7 below.)* ☐ Yes ☐ No
3. During the past 5 years, has any Proposed Insured consulted any physician for any reason not detailed above? ☐ Yes ☐ No
4. Is any Proposed Insured aware of any symptoms or complaints regarding their health for which they have not yet consulted a physician? ☐ Yes ☐ No
5. Has any Proposed Insured been advised to have surgery, treatment or testing which has not been completed? ☐ Yes ☐ No
6. Has any Proposed Insured ever used marijuana or any illegal or addictive drugs? ☐ Yes ☐ No
7. DETAILS: Enter complete details from questions #1-6 below. *(If additional space is needed, attach a separate sheet of paper.)*

Question #/Letter	Name *(First, MI Last)*	Relationship to Insured	Date of Condition *(MM/DD/YYYY)*	Health Condition & Details	Medical Care Provider's Name/Address/Phone
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
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			/ /		
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8. Has any immediate family member *(whether living or dead)* of any Proposed Insured ever suffered from, or is currently suffering from: Cancer, heart disease, stroke, kidney disease, diabetes, ALS *(Amyotrophic Lateral Sclerosis or Lou Gehrig's Disease)*, motor neuron disease, Alzheimer's Disease, Parkinson's Disease or any other hereditary disease prior to age 65? *(If YES, please provide details below. If additional space is needed, attach a separate sheet of paper.)* ☐ Yes ☐ No

Name *(First, MI, Last)*	Family Member/ Relationship	Diagnosis	Age at Time of Diagnosis

Q. 2 Include dosage with the RX in #7.

Include question number

Provide necessary info for **each** "yes" answer in questions 1-6. Attach sheet of paper if more space is needed.

Father, mother, brothers, sisters

Step 8 – Disability Income

Enter Base benefit amount requesting from illustration.

Beneficiary if insured dies after 12 mo. of DI benefits paid.

SDIR amount requesting from illustration.

Base benefit for rider available by benefit period chosen on base policy.

Business Overhead Expense not available to class 1A.

Regularly-recurring payments of monthly expenses to continue the business.

DISABILITY INCOME PRODUCT SECTION

Plan of Insurance: *(Check one)* ☐ Personal Disability Income *(PDI)* ☐ Business Overhead Expense Disability Income *(BOE)*
☐ Other *(Please specify)* _____

Monthly Base Amount $_____ Occupation Class: ☐ 4 A ☐ 3 A ☐ 2 A ☐ 1 A *(PDI only)*

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days *(PDI only)* ☐ 365 days *(PDI only)*

Benefit Period: ☐ 1 Year ☐ 2 Years ☐ 5 Years *(PDI only)* ☐ To age 65 *(PDI only)*

First *MI* *Last*

Person to receive Survivor Benefits: Name _____

(MM/DD/YYYY)

Relationship to Insured _____ Date of Birth ___/___/___

ADDITIONAL BENEFITS *(PDI only—If available)*

Check benefit(s) desired and indicate amount requested.

☐ Supplemental Disability Income Rider $_____ ☐ Residual Benefit Rider
☐ Guaranteed Insurability Rider ☐ Return of Premium Rider
☐ Hospital Benefit Rider ☐ Retroactive Injury Benefit Rider
☐ Non-Cancelable Rider ☐ 5-Year Own Occupation Rider
☐ Automatic Benefit Increase Rider ☐ Other *(Please specify)* _____ $_____
☐ Catastrophic Disability Income Rider *(Select desired Benefit Period for Catastrophic Disability Income Rider.)*

Available with 1 year Base Benefit Period: ☐ 4 Year Rider Benefit Period OR ☐ 9 Year Rider Benefit Period
Available with 2 year Base Benefit Period: ☐ 3 Year Rider Benefit Period OR ☐ 8 Year Rider Benefit Period
Available with 5 year Base Benefit Period: ☐ 5 Year Rider Benefit Period

ADDITIONAL INFORMATION *(BOE only)*

Average monthly expenses currently incurred, for which the Proposed Insured is liable:

Employees' salaries	$_____
Utilities *(electricity, gas, water, telephone)*	$_____
Business space *(rent/mortgage payment)*	$_____
Furniture/equipment payments *(lease or principal)*	$_____
Laundry, office maintenance	$_____
Business insurance premiums	$_____
Accounting fees	$_____
Property/payroll taxes	$_____
Other eligible expenses *(Please list)*	$_____
_____	$_____
_____	$_____
_____	$_____
TOTAL MONTHLY EXPENSES	$_____

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Step 9 – Graded Benefit Disability Income

Base benefit amount being requested.

This is the person to receive a benefit if insured dies after having received at least 12 months of benefit.

GRADED BENEFIT DISABILITY INCOME PRODUCT SECTION

Plan of Insurance: *(Check one)*: ☐ Graded Benefit Disability Income ☐ Other *(Please specify)* _____

Monthly Base Amount $ _____ Occupation Class: ☐ 4 A ☐ 3 A ☐ 2 A ☐ 1 A

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days *(Only available with 5 or 10 year Benefit Periods.)*

Benefit Period: ☐ 2 Years ☐ 5 Years ☐ 10 Years

Person to receive Survivor Benefits: Name _____ *First* *MI* *Last*

Relationship to Insured _____ Date of Birth *(MM/DD/YYYY)* ___/___/___

ADDITIONAL BENEFITS *(If available)*

Check benefit(s) desired and indicate amount requested.

☐ Supplemental Disability Income Graded Benefit Rider $ _____

☐ 5-Year Own Occupation Rider

☐ Non-Graded Injury Benefit

Step 10 – Physician Information

Enter information on insured's primary physician. Include reason for the last consultation.

PRIMARY PHYSICIAN INFORMATION

Name _____
First MI Last

Address _____
Street Address Suite

_____
City State ZIP+4

Phone No. ( ) — Fax No. ( ) —

Date last consulted (MM/DD/YYYY) / / Reason for consultation _____

Results _____

AGREEMENT

All parties must read the agreement and sign below.

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 shall form a part of the policy if attached thereto.

I (We) agree that:

a. 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.

b. 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: a) The application is approved by the Company at its Home Office, b) Such policy is issued and delivered to the Proposed Insured/Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. 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.

c. No agent or medical examiner has power to, 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.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Enter city and state wherein this contract is being signed.

Date app is signed

Signed at _____ on / /
City State Date (MM/DD/YYYY)

Signature of Proposed Insured

Signature of Additional Proposed Insured

Signature of Additional Proposed Insured

Signature of Parent/Guardian of Minor Child

Signature of Owner(s) (If other than Proposed Insured)

Signature of Beneficiary (If applying for Reversionary Annuity)

Signature of Licensed Agent

Print Agent Name and Agent No.

Signature of proposed insured, and all additional applicants on the application.

Parent/guardian must sign for a minor child. Owner of policy must also sign.

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Licensed agent sign and **print** name clearly. Include agent number. If pending, write "pending" or leave blank.

Step 11 — Field Underwriter's Statement

Q. 2a. If applicant was not seen, a paramed exam must be ordered.

Q 2d. A copy of BOTH the front and back is required.

Q 3 Refer to underwriting requirements in product guide or illustration.

Q4. MD form must be included with app whether replacing or not.

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions:

1. a. What amount was collected with this application? $ _____

   b. Has a Conditional Receipt been given to the Policyowner? ☐ Yes ☐ No

   c. Has an Authorization for Release of Medical Information been signed and a Fair Credit and MIB Notification been given to the Proposed Insured? ☐ Yes ☐ No

2. a. Did you personally see all Proposed Insured(s) on date of application? ☐ Yes ☐ No

   b. How well do you know the Proposed Insured(s)? ☐ Well ☐ Slightly ☐ Not at all

   c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? *(If YES, please provide details below.)* ☐ Yes ☐ No

   _____

   d. Is the Proposed Insured(s) a citizen of the United States? *(If NO, provide a copy of a permanent visa—front and back.)* ☐ Yes ☐ No

3. Is this application being submitted on a non-medical basis? *(If NO, check items below for which arrangements have been made.)* ☐ Yes ☐ No

   ☐ Abbreviated paramedical examination *(Tele-app only.)*

   ☐ Paramedical examination with Home Office *(H.O.)* specimen. *(Preferred classifications require blood profile, not dried blood spot.)*

   ☐ Medical exam by physician with H.O. specimen ☐ Chest X-ray ☐ Blood Profile ☐ Electrocardiogram ☐ Treadmill

   Name and address of examiner _____

   Date above items to be completed *(MM/DD/YYYY)* ____/____/____

4. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
   (If YES, please complete and return the appropriate State Replacement Form.)

5. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ ____% Agent No. _____ ____%

AUTOMATIC BANK WITHDRAWAL

☐ Set up NEW bank withdrawal—signed authorizations and voided check attached with the application.

Applicants and/or policy numbers to be included: _____

☐ Add to existing bank withdrawal on *(MM/DD/YYYY)* ____/____/____

LIST BILL

☐ Set up NEW list bill—complete Employer's Authorization and Case Agreement.

☐ Add to existing list bill; indicate List Bill No. _____

Name of Company _____

FOR LIFE APPLICATION

All LifeScape® Whole Life cases require either a signed illustration or a signed Illustration Disclosure Statement be submitted with the application.
The premiums for this application were quoted on the following underwriting classification:

☐ Preferred + ☐ Preferred ☐ Select Non-Tobacco ☐ Tobacco ☐ Preferred Tobacco

FOR REVERSIONARY ANNUITY APPLICATION

All cases require either a signed illustration or a signed Illustration Disclosure Statement be submitted with the application.
The premiums for this application were quoted on the following underwriting classification:

☐ Preferred Non-Tobacco ☐ Standard Non-Tobacco ☐ Tobacco

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.

_____	____/____/____	(____) ____— / (____) ____—
Signature of Soliciting Agent	*Date (MM/DD/YYYY)*	*Business Phone No. and Fax No.*
_____	_____	_____
Soliciting Agent's Printed Name	*Agent No.*	*Agent's E-mail*

For Home Office use only: Date received	*Policy No.*	*CWA$*

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