Georgia Application for **Single-Pay, 3-Pay, 5-Pay** and **10-Pay Single Life** and **Second to Die Single Whole Life Insurance**

This application includes all forms needed to apply for either insurance.

Thank you for your interest in writing business with Assurity Life Insurance Company.

To enable us to process your application more quickly, please review the following checklist:

- ✓ To comply with state regulations and protect your interest, you must be properly licensed and appointed by Assurity **in the state *in which the application is signed***.
- ✓ Use the appropriate application **for the state *in which the application is to be signed***.
- ✓ Print the application in black ink for faxing and photo copying purposes.
- ✓ Please verify that all questions on the application are answered.
- ✓ Use **age last birthday** when preparing illustrations and/or calculating insurance premiums.
- ✓ Obtain all required signatures.
- ✓ Have the Proposed Insured initial any changes. (Corrections with white correction fluid/tape are not acceptable.)
- ✓ Comply with all state regulations
  1. NAIC Model Illustration or disclosure statement must accompany any application.
  2. Complete all other pertinent and applicable forms padded together in this application.
- ✓ **If faxing an application directly to Legacy, fax to (402) 493-3507.**
- ✓ **If mailing directly to Legacy, address to:** **Legacy Insurance Services, Inc. of America**
  P.O. Box 668
  Boys Town, NE 68010-9924

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Application for LIFE INSURANCE

PLEASE PRINT WITH BLACK INK

PROPOSED INSURED

First	*Middle*	*Last*	*(MM/DD/YYYY)*
Legal Name			Date of Birth / /

Social Security No.	☐ Male ☐ Female	E-mail	Age

Street Address	*City*	*State*	*ZIP+4*
Home Address			

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

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

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number:

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

First	*Middle*	*Last*	*(MM/DD/YYYY)*
Legal Name			Date of Birth / /

Social Security No.	Relationship to Insured	Birth State/Country

Street Address	*City*	*State*	*ZIP+4*	
Home Address				E-mail

Contingent Owner's Name *First*	*Middle*	*Last*	Contingent Owner's Relationship to Insured

BENEFICIARIES

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Soc. Sec. No.**	**Date of Birth**	**Share %**
			/ /	
			/ /	
			/ /	

(If applying for Second-to-Die plan, the death benefit is payable upon the death of the second insured.)

PRODUCT SECTION

Plan: ☐ Single Life ☐ Second-to-Die **Base Amount** $ _____ **Death Benefit Option:** ☒ Level ~~☐ Increasing~~

Premium Payment Option: ☐ Single-pay ☐ 3-pay ☐ 5-pay ☐ 10-pay

Premium Payment Mode: Annual

Additional Benefit Available *(check benefit if desired)*: ☐ Accidental Death Benefit Rider *(available with Single Life, Single Premium Payment Option only.)*

AGREEMENT FOR THE PURCHASE OF A SINGLE PREMIUM DEFERRED ANNUITY

I understand that if I do not qualify for a single-pay life insurance policy as applied for above, the Company will issue a single premium annuity contract in the amount of: $ _____

Signed at _____ on / / by _____
City *State* *Date (MM/DD/YYYY)* *Signature of Proposed Annuitant*

/ / _____
Date (MM/DD/YYYY) *Signature of Owner*

GENERAL SECTION

1. During the past **5 years** or within the next **12 months**:
   a. Has the Proposed Insured flown other than as a fare-paying passenger, or is the Proposed Insured contemplating or planning to fly as a pilot, crew member or student? ☐ Yes ☐ No
   b. Has the Proposed Insured participated in, or is the Proposed Insured planning to participate in, any hazardous sport or activities? ☐ Yes ☐ No
   If YES, check all that apply: ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/Hang Gliding ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning
2. During the next **12 months**, does the Proposed Insured contemplate travel outside of the United States? ☐ Yes ☐ No
   If YES, please explain: _____
3. During the past **5 years**, has the Proposed Insured 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: _____
4. Is the Proposed Insured currently negotiating for other insurance coverage? ☐ Yes ☐ No
   If YES, please explain: _____
5. If this insurance is issued, will it replace, modify or borrow against existing or pending life and/or annuity coverage? ☐ Yes ☐ No
   If YES, please complete and return the appropriate State Replacement Form.
6. Does the Proposed Insured have other life insurance or annuity coverage in force? If YES, please provide details below. ☐ Yes ☐ No

Company Name	Policy No.	Face Amount	Issue Date *(MM/DD/YYYY)*	Being Replaced?
			/ /	☐ Yes ☐ No
			/ /	☐ Yes ☐ No

PRIMARY PHYSICIAN INFORMATION

First *Middle* *Last* — *Business Phone No. and Fax No.*

Name _____ Contact Nos. ( ) / ( )

Street Address *Suite No.* *City* *State* *ZIP+4* — *(MM/DD/YYYY)*

Address _____ Date last consulted / /

Reason for consultation _____ Results _____

HEALTH SECTION

1. During the past **10 years**, has the Proposed Insured received medical diagnosis or been treated 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
2. During the past **5 years**, has the Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:
   a. Alzheimer's disease, dementia, memory loss, seizures, mental retardation *(including Down's syndrome)*, multiple sclerosis *(MS)*, muscular dystrophy *(MD)*, Parkinson's disease, amyotrophic lateral sclerosis *(ALS)*, any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy, dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? ☐ Yes ☐ No
   b. Heart disorder, including a heart attack *(myocardial infarction)*, angina, irregular heart beat or abnormal heart rhythm *(arrhythmia)*, hypertension *(high blood pressure)*, heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack *(TIA or mini-stroke),* diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease *(other than kidney stones)*, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, bladder or prostate, other intestinal disease or pancreatitis, internal cancer or tumor, melanoma, lymphoma, leukemia or any glandular disorder? ☐ Yes ☐ No
3. During the past **5 years**, has the Proposed Insured:
   a. Needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing or dressing)*? ☐ Yes ☐ No
   b. Had or been advised to have an organ or tissue transplant? ☐ Yes ☐ No
   c. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician, or been treated by or been advised by a physician to seek treatment for drug or alcohol use? ☐ Yes ☐ No
   d. Been advised to have any test *(except HIV tests)*, treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which the results have not been received? ☐ Yes ☐ No
4. Is the Proposed Insured currently under treatment or taking prescription medication? ☐ Yes ☐ No
5. **DETAILS:** Enter complete details from questions #2-4 below. If additional space is needed, attach a separate sheet of paper.

Question #/Letter	Onset Date *(MM/DD/YYYY)*	Duration *(Days, Mos, Yrs)*	Health Condition and Details	Prescription Medication(s)	Medical Care Provider's Name/Address/Phone
	/ /				
	/ /				

SECOND PROPOSED INSURED

First	Middle	Last	(MM/DD/YYYY)
Legal Name			Date of Birth / /

Social Security No.	☐ Male ☐ Female	E-mail	Age

Street Address	City	State	ZIP+4
Home Address			

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

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

Is the Proposed Insured a United States citizen or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number:

GENERAL SECTION

1. During the past **5 years** or within the next **12 months**:

   a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured contemplating or planning to fly as a pilot, crew member or student? ..... ☐ Yes ☐ No

   b. Has the Proposed Insured participated in, or is the Proposed Insured planning to participate in, any hazardous sport or activities? ..... ☐ Yes ☐ No

   If YES, check all that apply:
   ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/Hang Gliding
   ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports
   ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning

2. During the next **12 months**, does the Proposed Insured contemplate travel outside of the United States? ..... ☐ Yes ☐ No

   If YES, please explain: _____

3. During the past **5 years**, has the Proposed Insured 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: _____

4. Is the Proposed Insured currently negotiating for other insurance coverage? ..... ☐ Yes ☐ No

   If YES, please explain: _____

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

6. Does the Proposed Insured have other life insurance or annuity coverage in force? If YES, please provide details below. ..... ☐ Yes ☐ No

Company Name	Policy No.	Face Amount	Issue Date (MM/DD/YYYY)	Being Replaced?
			/ /	☐ Yes ☐ No
			/ /	☐ Yes ☐ No
			/ /	☐ Yes ☐ No

PRIMARY PHYSICIAN INFORMATION

First	Middle	Last	Business Phone No. and Fax No.
Name			Contact Nos. ( ) / ( )

Street Address	Suite No.	City	State	ZIP+4	(MM/DD/YYYY)
Address					Date last consulted / /

Reason for consultation

Results

HEALTH SECTION

1. During the past **10 years**, has the Proposed Insured received medical diagnosis or been treated 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

2. During the past **5 years**, has the Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following:

   a. Alzheimer's disease, dementia, memory loss, seizures, mental retardation *(including Down's syndrome)*, multiple sclerosis *(MS)*, muscular dystrophy *(MD)*, Parkinson's disease, amyotrophic lateral sclerosis *(ALS)*, any brain or nervous system disorder, cerebral palsy or any form of muscular atrophy, dizziness, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? ☐ Yes ☐ No

   b. Heart disorder, including a heart attack *(myocardial infarction)*, angina, irregular heart beat or abnormal heart rhythm *(arrhythmia)*, hypertension *(high blood pressure)*, heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack *(TIA or mini-stroke),* diabetes, high blood sugar or sugar in the urine, anemia, blood or platelet disorders, elevated cholesterol, liver disease, hemophilia, kidney disease *(other than kidney stones)*, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, bladder or prostate, other intestinal disease or pancreatitis, internal cancer or tumor, melanoma, lymphoma, leukemia or any glandular disorder? ☐ Yes ☐ No

3. During the past **5 years**, has the Proposed Insured:

   a. Needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing or dressing)*? ☐ Yes ☐ No

   b. Had or been advised to have an organ or tissue transplant? ☐ Yes ☐ No

   c. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician, or been treated by or been advised by a physician to seek treatment for drug or alcohol use? ☐ Yes ☐ No

   d. Been advised to have any test *(except HIV tests)*, treatment, surgery, hospitalization or consultation with a medical professional which has not been completed, or for which the results have not been received? ☐ Yes ☐ No

4. Is the Proposed Insured currently under treatment or taking prescription medication? ☐ Yes ☐ No

5. **DETAILS:** Enter complete details from questions #2-4 below. If additional space is needed, attach a separate sheet of paper.

Question #/Letter	Onset Date *(MM/DD/YYYY)*	Duration *(Days, Mos, Yrs)*	Health Condition and Details	Prescription Medication(s)	Medical Care Provider's Name/Address/Phone
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				
	/ /				

AGREEMENT

I, the Proposed Insured, agree that:

1. All answers in this Application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability.
2. 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 Conditional Receipt, and **c.** the terms of the policy applied for.
3. If the first premium is not paid on the date this Application is signed, no insurance will be in effect unless: **a.** such policy is issued, delivered to and accepted by me, and the entire first premium is paid during my lifetime, and **b.** 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 knowledge.

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 subject to a substantial civil penalty where and to the extent allowed by state law as determined by a court of competent jurisdiction.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau Inc., that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. A photographic copy of this authorization shall be as valid as the original. **I agree** this authorization shall be valid for two years from the date shown below. **I understand** that I or my authorized representative may receive a copy of this authorization.

I, the Policyowner, 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.

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

_____ _____
Signature of Proposed Insured *Signature of Second Proposed Insured (if applicable)*

_____ _____
Signature of Parent/Guardian of Minor Child *Signature of Policyowner (if other than Proposed Insured)*

FIELD UNDERWRITER'S STATEMENT

Please answer the following questions regarding the Proposed Insured(s):

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

   b. Has a Conditional Receipt been given to the Proposed Insured(s)? ☐ Yes ☐ No

   c. Has a Notice of Investigative Consumer Report and Notice of Acquisition & Disclosure of Confidential Information been given to the Proposed Insured(s)? ☐ Yes ☐ No

2. a. Did you personally see the Proposed Insured(s) on the 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 their insurability? ☐ Yes ☐ No

   If YES, please provide details: _____

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

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

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.

_____ / _____ / _____ _____
Date (MM/DD/YYYY) *Signature of Soliciting Agent*

_____ _____
Agent No. *Soliciting Agent's Printed Name*

( ) _____ ( ) _____ _____
Business Phone No. *Fax No.* *Agent's E-mail*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

Legacy Estate Maximizer DISCLOSURE STATEMENT

Please carefully review the following information before signing this statement below. If you have any questions about the policy you are purchasing, please ask your agent or contact Assurity Life Insurance Company at (800) 276-7619, Ext. 4264.

I understand that:

- I am purchasing a single-premium whole life insurance policy—not an investment, annuity or savings vehicle—from Assurity Life Insurance Company.
- This policy should not be purchased with funds I need for routine living expenses or financial obligations.
- The money available to me through loan or surrender in the early policy years will be less than the premium I paid for this policy.
- If I need access to funds I used to buy this policy, I must take a policy loan, which will incur interest charges, or surrender the policy entirely.
- Any accrued loan amount will reduce the policy's death benefit or the amount received if the policy is surrendered.
- If I use proceeds from a **nonqualified** annuity to purchase this policy, I may pay withdrawal charges on that annuity and will pay income tax at ordinary rates on any gain in the annuity proceeds.
- If I use proceeds from a **qualified** annuity to purchase this policy, I may pay withdrawal charges on that annuity and will pay income tax at ordinary rates on the entire annuity proceeds.

I understand that I should discuss all tax consequences related to this purchase and policy with an independent tax advisor.

Your signature below indicates you understand each statement above.

Date (MM/DD/YYYY)	Signature of Proposed Insured	Print Name of Proposed Insured
/ /		
/ /		
Date (MM/DD/YYYY)	Signature of Joint Proposed Insured (if any)	Print Name of Joint Policyowner
/ /		
Date (MM/DD/YYYY)	Signature of Proposed Policyowner (if different than Proposed Insured)	Print Name of Proposed Policyowner
/ /		
Date (MM/DD/YYYY)	Signature of Licensed Agent	Print Agent Name and Agent No.

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619

Confidential Information AUTHORIZATION

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

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

Applicant/Insured/Claimant Child(ren)

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

I, on behalf of myself or the person named above *(Individual)*, authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau *(MIB)*, consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company *(Assurity),* its reinsurers and/or consumer reporting agencies and their authorized representatives *(provided, however, consumer reporting agencies may not collect information under this authorization from the MIB)*:

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation)*, occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus *(HIV)* infection and sexually transmitted diseases *(**Except** information about human immunodeficiency virus (HIV) infection for Individuals residing in Maine or Vermont.).* **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau *(MIB)*, consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below)***, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

_____
Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619

Confidential Information AUTHORIZATION

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

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

Applicant/Insured/Claimant Child(ren)

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

I, on behalf of myself or the person named above *(Individual)*, authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau *(MIB)*, consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to disclose to Assurity Life Insurance Company *(Assurity),* its reinsurers and/or consumer reporting agencies and their authorized representatives *(provided, however, consumer reporting agencies may not collect information under this authorization from the MIB)*:

- Information as to diagnosis, treatment and prognosis pertaining to medical history, mental or physical condition, pharmacy and/or prescription drug records, or treatment and information pertaining to mode of living (*except as may be related directly or indirectly to sexual orientation)*, occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of human immunodeficiency virus *(HIV)* infection and sexually transmitted diseases *(**Except** information about human immunodeficiency virus (HIV) infection for Individuals residing in Maine or Vermont.).* **For residents of Maine:** this authorization excludes disclosure of the results of a test for HIV if the Individual has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the Individual has AIDS. **For residents of Vermont:** this authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. The Individual is NOT authorizing Assurity to forward the results from any new test requested by Assurity to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.
- Information on diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.
- Information provided on applications to obtain driving records and credit information. The records obtained will be used to determine eligibility for insurance, including additional coverage to an existing policy. I authorize the release of any information contained in credit reports and driving records, including but not limited to information on motor vehicle accidents and/or violations.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, the MIB and to other insurance companies in which the Individual has policies or to whom applications may be made, or to whom claims for benefits have been made or may be submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Individual do not apply to this authorization, and I instruct any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau *(MIB)*, consumer reporting agency, clearinghouse, employer or other organization or person that has any records or knowledge of the Individual or their health to release and disclose the Individual's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance, including additional coverage to an existing policy and/or eligibility for benefits under a policy. I understand that this information may be subject to re-disclosure by Assurity and may no longer be protected by the federal rules governing privacy of health information, and that this information may only be redisclosed in accordance with other applicable laws or regulations.

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(Except for residents of Arizona, authorization to disclose HIV-related information is valid for 180 days from the date of the signature below)***, for collecting information in connection with an application for an insurance policy, policy reinstatement or claim. A copy of this authorization is as valid as the original. I understand that I, or my authorized representative, will receive a copy of this authorization if requested. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I further understand that if I refuse to sign this authorization, Assurity may not be able to process this application, or if coverage has been issued, may not be able to make any benefit payments.

This authorization complies with the Health Insurance Portability and Accountability Act *(HIPAA)* Privacy Rule.

_____ _____
Date (MM/DD/YYYY) *Signature of Applicant/Insured/Claimant, Legal Representative or Parent of Child(ren) under age 18*

_____ _____
Signature of Additional Applicant/Insured/Claimant or Legal Representative *Signature of Applicant/Insured/Claimant Child (if age 18 or older)*

_____
Description of Legal Representative's Authority for Applicant/Insured/Claimant (please indicate which Individual is represented)

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (888) 255-2060

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 Inc., formerly known as the Medical Information Bureau, a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at (866) 692-6901 *(TTY 866-346-3642)*. If you question the accuracy of the information in MIB's file, you may contact MIB to seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Ste. 400, Braintree, MA 02184-8734.

Assurity, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

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.

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Customer Identification INFORMATION

PLEASE PRINT WITH BLACK INK

ANTI-MONEY LAUNDERING PROGRAM REQUIRES THE AGENT TO COMPLETE THIS FORM, PROVIDING THE FOLLOWING INFORMATION:

Applicant/Owner Name _____ Social Security No. ___ — ___ — ____

1. Source of Funds

- ☐ Current Income
- ☐ Savings
- ☐ Another person *(if so, identify)* _____
- ☐ Proceeds of canceled life insurance policy
- ☐ From values of existing life insurance policy
- ☐ Other _____

2. Intended purpose of applied for coverage

- ☐ Burial/final expenses
- ☐ Retirement
- ☐ Mortgage pay-off
- ☐ Funding a charitable contribution
- ☐ Periodic Income
- ☐ Post-death family needs
- ☐ Educational expenses
- ☐ Business need *(e.g. key-person life insurance)*
- ☐ Other _____

3. Applicant's background

- ☐ Length of time known *(in years)* _____
- ☐ How known _____
- ☐ Nature of relationship _____
- ☐ Applicant's occupation _____

Business relationship with applicant? ☐ Yes ☐ No If so, describe _____

4. Any additional information you possess regarding the background of/your relationship with the applicant

_____

_____

5. Source of information

Name _____

☐ Applicant ☐ Owner ☐ Payor ☐ Other *(specify)* _____

I certify all of the above information is true and correct to the extent of my knowledge and reflects the information provided to me by the applicant, except where information from me is required.

_____ _____
Producer Signature *Producer No.*

_____ / /
Producer Name *Date (MM/DD/YYYY)*

Mail or fax this completed and signed form along with the application submitted to the home office.

ASSURITY LIFE INSURANCE COMPANY
1526 K STREET ● PO BOX 82533 ● LINCOLN, NEBRASKA 68501-2533 ● TOLL FREE 866-276-7619

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: _____

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

DISCLOSURE STATEMENT

MODIFIED ENDOWMENT CONTRACT

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 limits 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 IRS code section 7702A)* for a life insurance contract are exceeded, the life insurance contract becomes a Modified Endowment Contract.

The plan of insurance 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:

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 percent penalty tax unless the Owner is at least $59^1/_2$ years old, becomes disabled, or annuitizes the entire cash value. *(If the Owner is a corporation, such proceeds are subject to the 10 percent penalty tax at any time.)*

Death benefits of Modified Endowment Contracts paid to the beneficiary continue to be treated as life insurance proceeds and therefore are not subject to income tax.

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

/ /		
Date (MM/DD/YYYY)	*Signature of Owner/Proposed Owner*	*Printed Name*
Print Insured/Proposed Insured's Name (First, Middle, Last)		*Policy Number (if applicable)*

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Life Insurance or Annuity
REPLACEMENT NOTICE

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Georgia law gives you the right to obtain a policy summary statement from your existing insurer at any time. Ask the company or agent that sold you your existing policy to give you information about it.

The reverse side contains a checklist of some of the items you should consider in making your decision. TAKE TIME TO READ IT.

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

☐ If you wish a policy summary statement from your existing insurer, or insurers, check this box.

We are required to notify your existing company that you may be replacing their policy.

_____ _____
Applicant's Signature and Printed Name *Date (MM/DD/YYYY)*

_____ _____ _____ _____
Applicant's Address *City* *State* *Zip*

_____ _____
Agent's Signature and Printed Name *Date (MM/DD/YYYY)*

_____ _____ _____ _____
Agent's Address *City* *State* *Zip*

_____ _____ _____
Agent's Phone No. *Agent's Fax No.* *Agent's License No.*

INFORMATION ON POLICIES WHICH MAY BE REPLACED

COMPANY NAME	POLICY NO.	NAME OF INSURED

ORIGINAL TO APPLICANT
COPY TO REPLACING INSURER
COPY TO REPLACED INSURER

Signed form to be returned to home office

ITEMS TO CONSIDER

1. If the policy coverages are basically similar, premiums for a new policy may be higher because rates increase as your age increases.
2. Cash values and dividends, if any, may grow slower under a new policy initially because of the initial costs of issuing a policy.
3. Your present insurance company may be able to make a change on terms which may be more favorable than if you replace existing insurance with new insurance.
4. If you borrow against an existing policy to pay premiums on a new policy, death benefits payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.
5. Current interest rates are not guaranteed. Guaranteed interest rates are usually considerably lower than current rates. What rates are guaranteed?
6. Are premiums guaranteed or subject to change—up or down?
7. Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.
8. CAUTION, you are urged not to take action to terminate, assign or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you.

and

REMEMBER, you have ten *(10)* days following receipt of any individual life insurance policy to examine its contents. If you are not satisfied with it for any reason, you have the right to return it to the insurer at its home or branch office or to the agent through whom it was purchased, for a full refund of premium.

To be completed if replacing another company's policy
Signed form to be returned to home office
Applicant to receive a copy of this form at the time the application is taken

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-4591

Life Insurance or Annuity
REPLACEMENT NOTICE

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Georgia law gives you the right to obtain a policy summary statement from your existing insurer at any time. Ask the company or agent that sold you your existing policy to give you information about it.

The reverse side contains a checklist of some of the items you should consider in making your decision. TAKE TIME TO READ IT.

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

☐ If you wish a policy summary statement from your existing insurer, or insurers, check this box.

We are required to notify your existing company that you may be replacing their policy.

_____ _____
Applicant's Signature and Printed Name *Date (MM/DD/YYYY)*

_____ _____ _____ _____
Applicant's Address *City* *State* *Zip*

_____ _____
Agent's Signature and Printed Name *Date (MM/DD/YYYY)*

_____ _____ _____ _____
Agent's Address *City* *State* *Zip*

_____ _____ _____
Agent's Phone No. *Agent's Fax No.* *Agent's License No.*

INFORMATION ON POLICIES WHICH MAY BE REPLACED

COMPANY NAME	POLICY NO.	NAME OF INSURED

ORIGINAL TO APPLICANT
COPY TO REPLACING INSURER
COPY TO REPLACED INSURER

Signed form to be returned to home office

ITEMS TO CONSIDER

1. If the policy coverages are basically similar, premiums for a new policy may be higher because rates increase as your age increases.
2. Cash values and dividends, if any, may grow slower under a new policy initially because of the initial costs of issuing a policy.
3. Your present insurance company may be able to make a change on terms which may be more favorable than if you replace existing insurance with new insurance.
4. If you borrow against an existing policy to pay premiums on a new policy, death benefits payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.
5. Current interest rates are not guaranteed. Guaranteed interest rates are usually considerably lower than current rates. What rates are guaranteed?
6. Are premiums guaranteed or subject to change—up or down?
7. Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.
8. CAUTION, you are urged not to take action to terminate, assign or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you.

and

REMEMBER, you have ten *(10)* days following receipt of any individual life insurance policy to examine its contents. If you are not satisfied with it for any reason, you have the right to return it to the insurer at its home or branch office or to the agent through whom it was purchased, for a full refund of premium.

To be completed if replacing another company's policy
Signed form to be returned to home office
Applicant to receive a copy of this form at the time the application is taken

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 869-0355 • FAX (877) 864-6630

Life/Annuity TRANSFER/1035 EXCHANGE FORM

A. INSTRUCTIONS

1. Owner's signature and date of completion are required on this form.
2. For transfers or 1035 exchanges from annuities or life products, a replacement form must be completed if required by state.
3. Use a separate form for each company. Please print in black ink.

B. COMPANY INFORMATION

Current Trustee/Custodian/Insurance Company | ( ) *Telephone No.*

Company Address | *City* | *State* | *ZIP+4*

Contract/Policy/Account No. | *Investment Vehicle (CD, Mutual Fund, Life Insurance, Annuity)*

Insured/Annuitant's Full Name | *Social Sec. or Tax I.D. No.* | *Joint Insured/Annuitant's Full Name* | *Social Sec. or Tax I.D. No.*

Policyowner/Account Owner's Full Name (if different from Insured or Annuitant) | *Social Sec. or Tax I.D. No.* | *Joint Owner's Full Name (if applicable)* | *Social Sec. or Tax I.D. No.*

C. POLICY INFORMATION

The contract is: ☐ ENCLOSED ☐ NOT ENCLOSED *(partial exchange only)*

☐ LOST/DESTROYED—I certify that the policy is lost or destroyed. I also certify that the policy has not been assigned or pledged as collateral.

D. COMPANY DESIGNATION

On the basis of the authorization and/or assignment below, please liquidate the above assets and send the proceeds to:
Assurity Life Insurance Company, P.O. Box 82533, Lincoln, NE 68501-2533

Assurity Life Insurance Policy/Contract No.

E. TYPE OF TRANSFER

Please select one of the following options:

Please note: A transfer/surrender of a life insurance policy to an annuity, or an annuity to another annuity, qualifies as a 1035 exchange. A transfer/surrender of an annuity to a life insurance policy does NOT qualify as a 1035 exchange—any gain on your existing annuity will be subject to income tax.

☐ 1. **1035 EXCHANGE** from a nonqualified annuity or life insurance policy(ies) *(including IRS Section 457 Deferred Compensation)*.

I hereby make a complete and absolute assignment *(endorsement for contracts that are not assignable)* and transfer all rights, title and interest of every nature and character in and to the above policy to the insurance company indicated above in an exchange intended to qualify under Section 1035 of the Internal Revenue Code. I represent that the above policy is not subject to any pledge, assignment, levy or legal proceeding. Upon receipt, the insurance company is directed to surrender all or part of the policy and apply the value to an annuity or life insurance policy for which I have submitted an application.

I understand that by executing this assignment, I irrevocably waive all rights, claims and demands under the above policy. I am aware of all penalties which may apply.

I acknowledge that the insurer is furnishing this form and participating in this transaction as an accommodation to me, and the indicated insurer assumes no responsibility or liability for my tax treatment under Section 1035 of the Internal Revenue Code or otherwise.

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. In addition, 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.

In accordance with these directions, please remit the value indicated below:

☐ COMPLETE: Surrender/Liquidate all assets in my account totaling $ _____

☐ PARTIAL: Surrender/Liquidate assets totaling $ _____

Transfer the proceeds:

☐ IMMEDIATELY: I am aware of all penalties which may apply.

☐ UPON MATURITY Maturity date ___/___/___ *(MM/DD/YYYY)*

E. TYPE OF TRANSFER *(Continued)*

☐ 2. **TRANSFER NON-QUALIFIED ACCOUNT(S)**

In accordance with these directions, please remit the value indicated below:

☐ COMPLETE: Surrender/Liquidate all assets in my account totaling $ _____

☐ PARTIAL: Surrender/Liquidate assets totaling $ _____

Transfer the proceeds:

☐ IMMEDIATELY: I am aware of all penalties which may apply.

☐ UPON MATURITY Maturity date ____/____/____ *(MM/DD/YYYY)*

☐ 3. **TRANSFER QUALIFIED RETIREMENT ACCOUNT(S) *(CURRENT PLAN TYPE)***

☐ ROTH IRA ☐ Simple IRA ☐ Traditional IRA ☐ SEP IRA

☐ KEOGH ☐ 401*(k)* ☐ Qualified Retirement Plan

As owner of the plan indicated above, I hereby request a liquidation of this account to effect a transfer of assets to the Company designated in Section D. I have submitted an application to that Company to establish an account for this transfer.

In accordance with these directions, please remit the value indicated below:

☐ COMPLETE: Surrender/Liquidate all assets in my account totaling $ _____

☐ PARTIAL: Surrender/Liquidate assets totaling $ _____

Transfer the proceeds:

☐ IMMEDIATELY: I am aware of all penalties which may apply.

☐ UPON MATURITY Maturity date ____/____/____ *(MM/DD/YYYY)*

Is this a transfer to an existing account? ☐ YES ☐ NO If YES, provide policy no. _____

☐ 4. **TRANSFER OF ASSETS TO AN ANNUITY CONTRACT *(i.e. nonqualified mutual funds or bank account(s), does not include 1035 exchanges)***

☐ Annuity ☐ CD Maturity date ____/____/____ *(MM/DD/YYYY)*

☐ Bank or Credit Union Account ☐ Mutual Fund ☐ Other _____

As owner of the plan indicated above, I hereby request a liquidation of this account to effect a transfer of assets to the Company designated in Section D. I have submitted an application to that Company to establish an account for this transfer.

In accordance with these directions, please remit the value indicated below:

☐ COMPLETE: Surrender/Liquidate all assets in my account totaling $ _____

☐ PARTIAL: Surrender/Liquidate assets totaling $ _____

Transfer the proceeds:

☐ IMMEDIATELY: I am aware of all penalties which may apply.

☐ UPON MATURITY Maturity date ____/____/____ *(MM/DD/YYYY)*

Is this a transfer to an existing account? ☐ YES ☐ NO If YES, provide policy no. _____

F. SIGNATURES

Under penalty of perjury, I certify that the foregoing information is true, correct and complete.

Date (MM/DD/YYYY)	Signature of Contract Owner	Printed Name
____/____/____	_____	_____
____/____/____	_____	_____
Date (MM/DD/YYYY)	*Signature of Joint Owner (if applicable)*	*Printed Name*

SIGNATURE GUARANTEE	ASSURITY LIFE INSURANCE COMPANY
	By _____
	Title _____