

APPLICATION FOR LIFE INSURANCE

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

I, the Proposed Insured and Owner (unless another Owner is named below) hereby apply for insurance with Assurity Life Insurance Company ("the Company"), 1526 K Street, PO Box 82533, Lincoln, NE 68501-2533.

1. Proposed Insured's Name

(Print) Last _____ First _____ Initial _____ Sex M F Birthdate _____ / _____ / _____ Age _____
Mo. Day Year Nearest Birthday
Street Address _____ City _____ State _____ Zip _____ Birth State _____
Height _____ Weight _____ Social Security No. _____ Proposed Insured's Telephone No. _____

2. Plan of Insurance ATBI - Whole Life Ins

3. Death Benefit \$ _____

4. Premium \$ _____

Premium Payment Mode:

- Annually Quarterly
 Semiannually Monthly*

*Automatic Bank Withdrawal

5. Primary Beneficiary _____ Relationship _____

Contingent Beneficiary _____ Relationship _____

6. Owner's Name (if other than the Proposed Insured) _____

Owner's Address _____

Owner's Social Security No. _____ Relationship to Proposed Insured _____

7. Is the insurance applied for intended to replace any insurance or annuity now in force? If yes, furnish insurance company's name and address and the policy number to be replaced. (Agent: Submit required state replacement forms)..... Yes No

8. Tobacco Question (If the answer to this question is Yes, the Proposed Insured is not eligible for a Non-Tobacco rate.)
Has the Proposed Insured used tobacco or nicotine-based products in the last 12 months? Yes No

9. Medical Question (If any part of this question is answered Yes, the Proposed Insured is not eligible for coverage.)

Have you, the Proposed Insured:

a. been hospitalized, confined to a nursing home or received inpatient therapy at a medical facility more than once in the last two years, or are you currently hospitalized, confined to a nursing home, or receiving inpatient therapy at a medical facility? Yes No

b. in the last two years, been diagnosed as having, received medical treatment for or been advised to receive medical treatment for Alzheimer's disease, cystic fibrosis, senile dementia, internal cancer or melanoma, leukemia, liver disease, heart disease or coronary artery disease, stroke, kidney disease, emphysema or COPD, diabetes requiring insulin injection, alcoholism, drug or narcotic addiction or other substance abuse, had surgery for any heart or circulatory disease (except varicose veins), or received a transplant of any organ or tissue? (MEDICAL TREATMENT INCLUDES PRESCRIPTION MEDICATION AND/OR PHYSICIAN CONSULTATION.) Yes No

c. in the last five years, been advised by a physician to have surgery, be hospitalized, or be confined to a nursing facility and either not done so or are you in the process of scheduling surgery, hospitalization, or confinement in a nursing facility? Yes No

d. in the last five years, received from a member of the medical profession a diagnosis of or treatment for AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex)? (You need not disclose the results of AIDS tests.) Yes No

AGREEMENT: I, the Proposed Insured, agree that: 1) All answers in this Application are true and complete to the best of my knowledge and will be relied upon to determine insurability. 2) The first premium is equal to the full premium for the payment mode selected in Question 4 above. 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, including its suicide and contestability provisions. If the first premium is not paid on the date this Application is signed, no insurance will be in effect unless a) a policy is delivered to and accepted by the Owner 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. No agent is authorized to change or waive the terms of this Agreement.

Dated at _____ this _____ day of _____, _____
City, State Date Month Year

AGENT'S STATEMENT: I have truly and accurately recorded in this Application the information provided by the Proposed Insured and witnessed his or her signature. To the best of my knowledge, the insurance applied for

is is not intended to replace any insurance or annuities now in force.

Signature of Licensed Agent _____ Agent # _____

Signature of Proposed Insured _____

Signature of Owner (if other than Proposed Insured) _____

CONDITIONAL RECEIPT: Make all premium checks payable to Assurity Life Insurance Company. Please do not make checks payable to the agent or leave "payee" blank.

Received from _____ with the attached Application to the Company the sum of \$ _____ as payment of the first premium for the life insurance applied for.

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

the Company agrees to insure the Proposed Insured under this Conditional Receipt. The amount of insurance hereunder will be the lesser of the amount applied for, or the amount for which the Proposed Insured qualifies, but not to exceed \$25,000 for any individual applying for insurance with either Company.

This Conditional Receipt terminates the earlier of a) 60 days after the date the Application was signed, or b) the date the insurance applied for becomes effective. If one or more of the conditions are not met, the Company's liability will be limited to the return of the sum received. This Conditional Receipt is controlled by the terms of the policy applied for. No agent is authorized to change or alter this Conditional Receipt.

Agent's Signature

Agent's Name

Date

NOTICE TO PROPOSED INSURED, including the notices required by the Fair Credit Reporting Act and the Medical Information Bureau, Inc.

The Company relies primarily on the information you provide in your Application to properly underwrite and administer your insurance coverage. This notice is a general description of the practices followed by the Company and by your agent to manage your personal information.

As a part of the normal procedure for processing your application, an investigative consumer report may be prepared. The Company obtains information as to your character, general reputation, personal characteristics and mode of living (except as relates to sexual orientation). Upon your written request to the Company, you have the right to receive additional, detailed information about the nature and scope of this investigation. You may also elect to be interviewed in connection with the preparation of an investigative consumer report, and to request and receive a copy of any investigative consumer report.

Information about your insurability will be treated as confidential. The Company or its reinsurers may make a brief report thereon to the Medical Information Bureau ("the Bureau"), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in your file. At your written request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

In some situations, and as allowed by law, necessary items of information may be disclosed to third parties without your specific authorization. The Company or its reinsurers may release information in our 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. Generally, you have a right to be told about, to see and to receive a copy of information about you contained in the Company's files. You also have the right to seek correction of information you believe to be incorrect. The Company will provide a more detailed description of its information practices at your written request. Please send your request to the address shown below for the Company to which you are applying for insurance.

Assurity Life Insurance Company
PO Box 82533, Lincoln, Nebraska 68501-2533
Toll Free (800) 276 - 7619, Ext. 4264 Internet: www.assurity.com

AfterThoughts Birthday InsuranceSM
 LifeScape® Simplified Whole Life
 Beneficiary Page Attachment

	Primary Beneficiaries	Relationship	Sex M/F	Date of Birth	First name to use in Greeting Card	Name of Sender to use in Greeting Card
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
	Contingent beneficiary	Relationship	Sex M/F	Date of Birth	First name to use in Greeting Card	Name of Sender to use in Greeting Card
1						

**LifeScape® Simplified Life
Policy Form A-L N00 (Assurity)**

Guaranteed Cash Value per \$1000 - Male													
*Issue Age	Year						Issue Age	Year					
	5	10	20	30	40	50		5	10	20	30	40	50
1	0.00	15.65	56.71	115.89	205.05	323.54	41	41.73	122.81	309.52	512.32	694.09	827.26
2	0.00	17.26	69.20	121.41	213.75	335.49	42	43.66	127.87	319.91	525.61	705.69	836.68
3	0.13	18.78	81.76	127.11	222.62	347.64	43	45.66	133.06	330.47	538.80	716.96	847.57
4	0.90	20.23	94.47	133.02	231.73	360.00	44	47.78	138.39	341.17	551.75	727.74	859.87
5	1.71	21.56	107.33	139.14	241.07	372.54	45	49.98	143.80	351.95	564.35	737.93	874.28
6	2.51	22.74	120.35	145.44	250.61	385.24	46	52.29	149.33	362.80	576.57	747.54	891.10
7	3.27	23.75	133.53	151.93	260.37	398.10	47	54.66	154.93	373.73	588.42	756.64	910.28
8	3.92	24.59	146.83	158.58	270.36	411.12	48	57.07	160.66	384.76	599.98	765.35	931.14
9	4.42	25.33	160.29	165.41	280.59	424.34	49	59.47	166.50	395.92	611.36	773.87	952.34
10	4.77	26.02	173.81	172.43	291.07	437.76	50	61.82	172.49	407.24	622.64	782.46	1000.00
11	4.94	26.70	187.31	179.65	301.82	451.37	51	64.12	178.61	418.65	633.81	791.44	n/a
12	4.98	27.45	200.81	187.09	312.85	465.17	52	66.40	184.86	430.11	644.81	801.23	n/a
13	4.95	28.36	214.31	194.81	324.17	479.16	53	68.71	191.21	441.47	655.49	812.39	n/a
14	4.97	29.48	227.81	202.85	335.81	493.30	54	71.10	197.64	452.59	665.66	823.64	n/a
15	5.08	30.89	241.31	211.28	347.74	507.57	55	73.63	204.12	463.36	675.22	834.63	n/a
16	5.35	32.63	254.81	220.03	359.99	521.95	56	76.27	210.63	473.72	684.14	845.82	n/a
17	5.82	34.68	268.31	229.18	372.54	536.45	57	79.02	217.19	483.70	692.51	857.23	n/a
18	6.52	37.05	281.81	238.72	385.41	551.05	58	81.77	223.81	493.36	700.48	868.12	n/a
19	7.40	39.67	295.31	248.60	398.55	565.77	59	84.42	230.51	502.84	708.27	878.86	n/a
20	8.47	42.51	308.81	258.80	411.97	580.56	60	88.87	238.96	513.29	716.84	1000.00	n/a
21	9.68	45.54	322.31	269.31	425.61	595.38	61	93.71	247.93	523.93	726.14	n/a	n/a
22	11.02	48.70	335.81	280.06	439.42	610.12	62	98.53	256.95	534.43	735.58	n/a	n/a
23	12.43	51.97	349.31	291.01	453.36	624.68	63	103.45	265.90	544.61	744.93	n/a	n/a
24	13.91	55.33	362.81	302.14	467.35	638.92	64	108.58	274.80	554.24	754.19	n/a	n/a
25	15.41	58.76	376.31	313.40	481.36	652.76	65	114.03	282.92	563.17	763.30	n/a	n/a
26	16.93	62.24	389.81	324.79	495.36	666.16	66	119.75	290.81	571.38	772.68	n/a	n/a
27	18.46	65.77	403.31	336.31	509.35	679.15	67	125.61	298.27	578.96	782.35	n/a	n/a
28	20.00	69.35	416.81	347.98	523.36	691.80	68	131.35	305.36	586.09	792.32	n/a	n/a
29	21.56	72.99	430.31	359.84	537.43	704.20	69	136.64	312.24	593.04	801.39	n/a	n/a
30	23.13	76.67	443.81	371.89	551.56	716.42	70	141.25	319.02	600.25	1000.00	n/a	n/a
31	24.72	80.41	457.31	384.13	565.70	728.45	71	145.13	325.74	608.36	n/a	n/a	n/a
32	26.34	84.20	470.81	396.54	579.80	740.23	72	148.40	332.38	618.25	n/a	n/a	n/a
33	27.97	88.06	484.31	409.09	593.74	751.66	73	151.38	338.79	631.14	n/a	n/a	n/a
34	29.62	92.00	497.81	421.73	607.41	762.58	74	154.58	344.77	648.68	n/a	n/a	n/a
35	31.28	96.02	511.31	434.43	620.70	772.93	75	158.38	350.22	672.44	n/a	n/a	n/a
36	32.96	100.14	524.81	447.18	633.60	782.70	76	162.85	355.12	703.70	n/a	n/a	n/a
37	34.63	104.36	538.31	459.98	646.13	791.97	77	167.86	359.58	742.82	n/a	n/a	n/a
38	36.34	108.72	551.81	472.88	658.35	800.87	78	172.89	363.78	788.64	n/a	n/a	n/a
39	38.09	113.25	565.31	485.90	670.39	809.56	79	177.21	367.99	837.99	n/a	n/a	n/a
40	39.88	117.94	578.81	499.06	682.31	818.27	80	180.33	372.79	1000.00	n/a	n/a	n/a

Annual Premium Per \$1000				
*Issue Age	Male		Female	
	Non-Tob	Tobacco	Non-Tob	Tobacco
1	7.98	n/a	6.02	n/a
2	8.28	n/a	6.27	n/a
3	8.63	n/a	6.56	n/a
4	8.99	n/a	6.84	n/a
5	9.35	n/a	7.15	n/a
6	9.76	n/a	7.47	n/a
7	10.07	n/a	7.81	n/a
8	10.23	n/a	8.14	n/a
9	10.40	n/a	8.27	n/a
10	10.57	n/a	8.40	n/a
11	10.74	n/a	8.54	n/a
12	10.91	n/a	8.68	n/a
13	11.09	n/a	8.82	n/a
14	11.27	n/a	8.96	n/a
15	11.45	12.60	9.11	9.66
16	11.64	12.80	9.26	9.82
17	11.83	13.01	9.41	9.97
18	12.02	13.22	9.80	10.19
19	12.26	13.48	10.13	10.75
20	12.50	13.75	10.65	11.30
21	12.74	14.00	10.87	11.62
22	12.98	14.25	11.10	11.94
23	13.23	14.50	11.33	12.27
24	13.50	14.80	11.56	12.62
25	13.78	15.16	11.80	12.98
26	14.08	15.60	12.03	13.36
27	14.39	16.11	12.26	13.75
28	14.72	16.66	12.49	14.16
29	15.08	17.23	12.76	14.59
30	15.48	17.80	13.07	15.03
31	15.92	18.34	13.43	15.47
32	16.40	18.86	13.83	15.91
33	16.91	19.40	14.27	16.38
34	17.45	20.01	14.73	16.90
35	18.02	20.72	15.21	17.50
36	18.60	21.52	15.70	18.18
37	19.20	22.40	16.21	18.92
38	19.83	23.35	16.75	19.73
39	20.52	24.40	17.33	20.61
40	21.29	25.54	17.97	21.56
41	22.15	26.78	18.70	22.59
42	23.10	28.10	19.50	23.70
43	24.10	29.53	20.34	24.88
44	25.13	31.05	21.16	26.12
45	26.16	32.70	21.93	27.41
46	27.18	34.42	22.59	28.76
47	28.20	36.20	23.17	30.17
48	29.25	38.12	23.75	31.64
49	30.36	40.23	24.40	33.15
50	31.56	42.61	25.22	34.68
51	32.84	45.25	26.21	36.17
52	34.18	48.10	27.33	37.64
53	35.59	51.18	28.54	39.17
54	37.08	54.47	29.82	40.86
55	38.66	57.99	31.15	42.83
56	40.28	61.83	32.51	45.04
57	41.93	65.98	33.93	47.41
58	43.69	70.31	35.41	50.01
59	45.63	74.67	36.97	52.86
60	47.83	79.22	38.63	56.01
61	50.25	82.90	40.32	59.52
62	52.84	86.69	42.04	63.37
63	55.66	90.66	43.87	67.45
64	58.75	94.74	45.91	71.89
65	62.16	99.49	48.26	76.00
66	65.87	104.72	50.85	80.23
67	69.78	110.27	53.62	84.44
68	74.03	116.26	56.66	88.85
69	78.71	122.83	60.07	93.67
70	83.94	130.11	63.94	99.11
71	89.68	138.49	68.26	105.48
72	95.88	147.87	72.97	112.62
73	102.55	157.68	78.08	120.10
74	109.76	167.35	83.59	127.47
75	117.52	176.28	89.52	134.28
76	125.76	184.23	95.80	140.33
77	134.45	191.58	102.42	145.92
78	143.73	198.72	109.48	151.34
79	153.71	206.02	117.09	156.91
80	164.53	213.89	125.33	162.93

Guaranteed Cash Value per \$1000 - Female													
*Issue Age	Year						Issue Age	Year					
	5	10	20	30	40	50		5	10	20	30	40	50
1	0.00	10.03	45.15	96.35	170.57	269.29	41	30.83	95.77	254.22	453.03	663.23	827.92
2	0.00	11.23	47.64	100.99	177.76	279.99	42	32.30	99.77	264.40	468.71	678.94	840.16
3	0.00	12.38	50.17	105.77	185.07	289.71	43	33.89	103.97	275.02	484.71	694.33	853.03
4	0.00	13.54	52.80	110.73	192.57	300.25	44	35.56	108.33	285.97	500.85	709.25	866.94
5	0.00	14.69	55.51	115.84	200.26	311.07	45	37.33	112.86	297.20	516.99	723.59	882.33
6	0.00	15.83	58.32	121.15	208.16	322.16	46	39.18	117.59	308.71	533.05	737.35	899.47
7	0.09	16.95	61.23	126.61	216.27	333.54	47	41.10	122.54	320.52	549.00	750.57	918.31
8	0.62	18.07	64.24	132.23	224.61	345.28	48	43.08	127.77	332.73	564.88	763.33	938.26
9	1.13	19.20	67.35	137.99	233.19	357.41	49	45.10	133.38	345.47	580.76	775.77	958.16
10	1.60	20.33	70.58	143.90	242.00	369.96	50	47.18	139.39	358.79	596.67	788.08	1000.00
11	2.03	21.48	73.93	149.94	251.05	382.95	51	49.35	145.84	372.70	612.56	800.49	n/a
12	2.45	22.69	77.41	156.14	260.37	396.34	52	51.65	152.69	387.11	628.33	813.31	n/a
13	2.87	23.97	81.07	162.50	269.96	410.09	53	54.15	159.90	401.89	643.80	826.95	n/a
14	3.32	25.33	84.90	169.06	279.81	424.12	54	56.98	167.37	416.86	658.82	841.91	n/a
15	3.81	26.79	88.92	175.84									

UNDERWRITING AUTHORIZATION AND ELECTION

Name of Proposed Insured ("Applicant") _____

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

- 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 the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.

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

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire 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 when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company or Parent Company and may no longer be protected by the federal rules governing privacy of health information.

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

I acknowledge receipt of Company's or Parent Company's Description of Information Practices which includes notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request and that a photographic copy of this authorization shall be as valid as the original.

I elect to be interviewed if an investigative consumer report is prepared in connection with my application(s) for insurance.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under the law.

Signature of Proposed Insured or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Insured _____

UNDERWRITING AUTHORIZATION AND ELECTION

Name of Proposed Insured ("Applicant") _____

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

- Psychotherapy notes.

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

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Applicant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose Applicant's entire psychotherapy notes as described above without restriction. The medical information so acquired will be used to determine eligibility for insurance (including additional coverage to an existing policy) and/or eligibility for benefits under a policy. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the Company or Parent Company and may no longer be protected by the federal rules governing privacy of health information.

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

I acknowledge receipt of Company's or Parent Company's Description of Information Practices which includes notices required by the Fair Credit Reporting Act and MIB. I understand that I will receive a copy of this authorization upon request and that a photographic copy of this authorization shall be as valid as the original.

I elect to be interviewed if an investigative consumer report is prepared in connection with my application(s) for insurance.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under the law.

Signature of Proposed Insured or Personal Representative _____ Date _____

Description of Personal Representative's Authority or Relationship to Insured _____

Customer Identification Information

(to be completed by the agent)

Assurity Life Insurance Company • P.O. Box 82533 • Lincoln, Nebraska 68501-2533 • 800-276-7619 • FAX 402-437-4591

Applicant/Owner Name _____ Social Security No. _____

ASGI'S MONEY-LAUNDERING PROGRAM REQUIRES YOU TO PROVIDE THE FOLLOWING INFORMATION:

1. Source of Funds

- | | |
|---|--|
| <input type="checkbox"/> Current Income | <input type="checkbox"/> Proceeds of canceled life insurance policy |
| <input type="checkbox"/> Savings | <input type="checkbox"/> From values of existing life insurance policy |
| <input type="checkbox"/> Another person (if so, identify) _____ | <input type="checkbox"/> Other _____ |

2. Intended purpose of applied for coverage

- | | |
|--|---|
| <input type="checkbox"/> Burial/final expenses | <input type="checkbox"/> Post death family needs |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Educational Expenses |
| <input type="checkbox"/> Mortgage pay-off | <input type="checkbox"/> Business need (e.g. key-person life insurance) |
| <input type="checkbox"/> Funding a charitable contribution | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Periodic Income | |

3. Applicant's background

- | | |
|--|---|
| <input type="checkbox"/> Length of time known (in years) _____ | <input type="checkbox"/> How known _____ |
| <input type="checkbox"/> Nature of relationship _____ | <input type="checkbox"/> Applicant's occupation _____ |
| Business Relationship with applicant? <input type="checkbox"/> Yes <input type="checkbox"/> 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, NE 68501-2533
Phone: 800-276-7619, Ext. 4264 • Fax 402-437-4558

Automatic Bank Withdrawal

Automatic Bank Withdrawal conveniently pays your premium from your checking account – saving you time and money. To begin this convenient service, please complete the form below and return it to us. Remember to indicate the date of withdrawal that would be most convenient for you.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account.

DRAFT INITIAL PREMIUM PAYMENT:

Yes No

If Yes is marked, the first premium for this insurance will be debited from your account at the time the policy is issued.

Name of Financial Institution Routing Number Account Number
(9 digit number beginning with 0, 1, 2, or 3)

Date of Withdrawal: _____ (cannot be the 29th, 30th or 31st)
IF NO DATE IS ENTERED, THE POLICY ISSUE DATE WILL BE USED

Type of account: Checking Savings

Signature of Account Holder Date Signed Telephone Number

Policy Number(s) (if applicable): _____

ATTACH VOIDED CHECK HERE