**Assurity Life Insurance Company**

# 2010 Statement of Health

☐ Life Insurance

Amount of Coverage Requested:
$ _____

Employee Social Security No. _____

Campus ☐ UNL ☐ UNMC ☐ UNO
Location ☐ UNK ☐ UNCA ☐ ANCL

**COMPLETE BOTH SIDES**

☐ Dependent Life Insurance

Amount of Coverage Requested:
Spouse $ _____
Children $ _____

| 1. Proposed Insured | Print Name in Full | Resides w/ Employee | Social Security No. | Sex | Birth Date | Age | Birth Place *(State)* | Ht. | Wt. *(lbs.)* |
|---|---|---|---|---|---|---|---|---|---|
| Employee | | | | | | | | | |
| Spouse | | | | | | | | | |
| Children | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| | Employee YES | Employee NO | Spouse YES | Spouse NO | Children YES | Children NO |
|---|---|---|---|---|---|---|
| 2. During the past five years, has any Proposed Insured: a. Had a driver's license denied, revoked, suspended: or had three or more moving violations, two or more traffic accidents or been convicted of driving while under the influence of alcohol or drugs? Please list family members' driver's license no. and issuing state: Employee _____ Spouse _____ Child _____ Child _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Had an x-ray, electrocardiogram, blood, urine, or any other kind of medical test? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Been to a clinic, hospital, or place for medical care or counseling? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Been aware of any condition that might need medical care *(such as pain, bleeding, enlargement of lymph nodes, dizziness, infection, shortness of breath, lump, growth or abnormal test)*? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. Taken any kind of medication or treatment? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Been arrested for or convicted of a felony? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. Applied for disability benefits? | | | ☐ | ☐ | ☐ | ☐ |
| 3. Has any Proposed Insured ever: a. Consulted with, or been diagnosed or treated by a medical professional for cancer, diabetes, stroke, heart or blood disorder, kidney, colon or liver disorder, lung or breathing disorder or rheumatoid arthritis? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Had treatment for AIDS *(Acquired Immune Deficiency Syndrome)*, ARC *(AIDS Related Complex)*, or any other immune system disorder; or a positive test for HIV *(Human Immunodeficiency Virus)* antibodies? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Has any Proposed Insured used any form of nicotine, including substitutes such as patches or gum? *(If YES, who, type and date last used.)* Employee _____ Spouse _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**IF YES TO ANY OF THE ANSWERS ABOVE, PLEASE GIVE DETAILS BELOW**

| Question No./Letter | Name of Individual | Treatment Date | Details | Remaining Effects | Medical Provider's Name/Address |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
| | | | | | |

| | Employee YES | Employee NO | Spouse YES | Spouse NO | Children YES | Children NO |
|---|---|---|---|---|---|---|
| 5. Family History: Has any Proposed Insured's father, mother, brother(s), or sister(s) had diabetes, cancer, heart, blood vessel or kidney disease, or a hereditary disorder? *(If YES, give details below.)* | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| Relationship | Disease | If Living, Age | If Deceased, Age at Death | Date of Death | Cause of Death |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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## AUTHORIZATION AND ACKNOWLEDGEMENT

I acknowledge receipt of a notice to me that the company may get information about my health, use of drugs or alcohol, occupation and hobbies. The purpose is for considering my application for insurance.

I authorize any medical practitioner, medical facility, insurance company and the Medical Information Bureau to give information about me or my family *(if they are listed on this application)* to Assurity Life Insurance Company or its reinsurers. This authorization will last for 26 months and a copy will be as valid as the original. I *(or my authorized representative)* am entitled to receive a copy of this authorization.

Signature of Proposed Insured *(or Owner for juveniles)* _____ Signature of Spouse *(if proposed for insurance)* _____

Date _____ Signed at *(City, State)* _____

# AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO ASSURITY LIFE INSURANCE COMPANY

**P.O. Box 82533 • Lincoln, Nebraska 68501-2533 • (402) 434-9500 (800) 284-8575**

**This authorization complies with the HIPAA Privacy Rule.**

Name of Applicant/Insured *(please print)* | Date of Birth

Name of Applicant/Insured Spouse *(please print)* | Date of Birth

**Applicant/Insured Children and Dates of Birth *(please print)***

| Name | Date of Birth | Name | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider *(Providers)* that has provided payment, treatment or services to the person named above, or on such person's behalf, to disclose the entire medical record and any other protected health information concerning such person for the past ten years to Assurity Life Insurance Company *(Assurity)* and its agents, employees, representatives and affiliates, including consulting physicians, attorneys and companies that perform services on their behalf such as underwriting activities and claims adjudication, the MIB, and as otherwise permitted by law or specifically authorized by me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus *(HIV)* infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements such person has made to restrict protected health information 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 the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Assurity and its affiliates may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment decisions; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage the person named above has or has applied for with Assurity.

This authorization shall remain in force for 26 months following the date of my 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 in writing, at any time, by sending a written request for revocation to Assurity Life at P.O. Box 82533, Lincoln, Nebraska 68501-2533, Attention: Law Department. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that Assurity has a legal right to contest a claim under an insurance policy or to contest the validity of the policy itself. I understand that Assurity will only use any information obtained pursuant to this authorization for the above-numbered purposes. Carrying out those purposes could include re-disclosure not protected by federal privacy regulations if such a disclosure is made to a person or entity not defined as a health plan or a health care provider under federal rules.

I understand that if I refuse to sign this authorization to release complete medical records, Assurity and its affiliates may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.

Signature of Applicant/Insured, Legal Representative or Parent of Children under age 18 | Date

Signature of Applicant/Insured Spouse or Legal Representative | Date

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

Signature of Applicant/Insured Child *(if age 18 or older)* | Date

Signed at *(City, State)* | Witness

Applicant's Current Address *(Street, City, State, Zip)* | Applicant's Phone Number

**In order to consider your application for insurance, you may have to complete one or more of the following:** Exam, Blood Profile, Home Office Urine Specimen or EKG

Assurity Life Insurance Company will pay for these tests. The tests performed include: determination of blood cholesterol and related lipids *(fats)*, HIV antibody tests, screening for liver or kidney disorders, diabetes, immune disorders, medication and drug screens.

You will be called by APPS Paramedical Services to arrange to have these tests completed. **These tests must be completed within 90 days from the date of application.** APPS Paramedical Services is quick, reliable, convenient and they specialize in insurance examinations.

If you have any questions, please let us know: Assurity Life Underwriting Department, 1-800-284-8575.

# NOTICE OF INSURANCE INFORMATION PRACTICES
## ASSURITY LIFE INSURANCE COMPANY

**P.O. Box 82533 • Lincoln, Nebraska 68501-2533 • Telephone: (402) 434-9500 (800) 573-9144**

## NOTICE REGARDING FRAUD

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 subjects such person to criminal and civil penalties.

## NOTICE REGARDING MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. ALIC or its reinsurers may, however, make a brief report thereon to MIB, a not-for-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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 *(TTY 866-346-3642)*. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

ALIC or its reinsurers may also release information in 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.

ALIC may need to obtain information from you and other sources to see if you qualify for insurance. An investigative consumer report may be prepared by an independent agency containing information about your character, habits, general reputation, personal characteristics and mode of living *(except as related directly or indirectly to sexual orientation)*. This information may be obtained through personal interviews with you, your neighbors, friends, associates and acquaintances. In certain circumstances, ALIC may be required by a law enforcement or governmental agency to furnish information to others without your specific authorization.

If a report is obtained, you have the right to be interviewed concerning the preparation of the report, and upon request, you are entitled to receive a copy of the report. You may request disclosure of the nature and scope of the investigation by writing ALIC within a reasonable time after receiving this notice. You may seek correction of information you believe to be inaccurate. Please send requests to the Customer Service Department, Assurity Life Insurance Company, P.O. Box 82533, Lincoln, Nebraska 68501-2533.

## ADVERSE UNDERWRITING DECISION

After a review of the application submitted on the Proposed Insured(s), ALIC will notify you in writing if the contract cannot be issued as applied for. To learn the specific reasons for this decision, you can make a written request within 90 days of the postmark on the notice. ALIC will reply in writing within 21 business days of receiving your request. Send your written request to the Underwriting Department, Assurity Life Insurance Company, P.O. Box 82533, Lincoln, Nebraska 68501-2533.