**Assurity Life Insurance Company**

# 2013 Statement of Health

**PLEASE PRINT WITH BLACK INK**

Coverage requested:
- ☐ Life – Employer-provided
- ☐ Life - Voluntary
- ☐ Dependent Life Insurance

Amount of coverage requested:
- Employee $ _____
- Spouse $ _____
- Children $ _____

Employee NU ID no. _____ Campus location: ☐ UNL ☐ UNMC ☐ UNO ☐ UNK ☐ UNCA ☐ ANCL

Employee e-mail _____ Daytime or cell phone no. ( ) _____

| 1. Proposed Insured | Print full legal name | Social Security No. | Sex | Birth date *(MM/DD/YYYY)* | Age | Birthplace *(State)* | Height | Weight *(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 or 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 _____ Children _____ | | | | | | |
| b. Had an X-ray, electrocardiogram or 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. During the past ten years, has any Proposed Insured 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? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Has any Proposed Insured ever 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? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Has any Proposed Insured ever used any form of nicotine, including substitutes such as patches or gum? If YES, please list whom, what type and date last used. Employee _____ Spouse _____ Children _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**IF YES TO ANY OF THE ANSWERS ABOVE, PLEASE GIVE DETAILS BELOW** *(If additional space is needed, attach a separate sheet of paper.)*

| Question no./letter | Name of individual | Date of treatment | Details | Remaining effects | Medical provider's name and address |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

| | Employee YES | Employee NO | Spouse YES | Spouse NO | Children YES | Children NO |
|---|---|---|---|---|---|---|
| 6. 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 *(if additional space is needed, attach a separate sheet of paper)*. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| Relationship | Disease | If living, age | If deceased, age at death | Date of death | Cause of death |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## 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.

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

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

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

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

# Confidential Information AUTHORIZATION

**PLEASE PRINT WITH BLACK INK**

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

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

_____ ( ) _____
*Applicant/Insured/Claimant's Current Address (Street, City, State, Zip Code)* — *Applicant/Insured/Claimant's Phone No.*

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)*

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# CONSUMER NOTICE

## MIB Pre-Notice

Information regarding your insurability will be treated as confidential. Assurity or its reinsurers may, however, make a brief report thereon to the MIB 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.