**Assurity® Life Insurance Company**
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

# GROUP PARTICIPANT ENROLLMENT FORM

**PLEASE PRINT WITH BLACK INK**

☐ **New Enrollee**
☐ **Coverage Change** Group Name ____________ Location ____________ Requested Issue Date *(MM/DD/YYYY)* ___/___/___

## A. Participant Information

| | | | |
|---|---|---|---|
| Applicant's Legal Name | *First, Middle, Last* | Date of Birth | *(MM/DD/YYYY)* / / |
| Applicant's Mailing Address | *Street Address* *City* *State* *ZIP+4* | | |
| Applicant's Email Address | | Personal Phone Number | ( ) |
| ☐ Male ☐ Female | Social Security No. | Birth State/Country | |
| Date of Employment *(MM/DD/YYYY)* / / | Hours per week | Annual Salary | $ |

Are you employed at least 20 hours per week, working your normally scheduled hours and able to perform the regular duties of your job? ☐ Yes ☐ No
If NO, please explain.

During the past **12 months**, has any Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum?
Applicant .............. ☐ Yes ☐ No
Spouse.................. ☐ Yes ☐ No

### SPOUSE INFORMATION:

| | | | |
|---|---|---|---|
| Spouse's Legal Name | *First, Middle, Last* | Date of Birth | *(MM/DD/YYYY)* / / |
| ☐ Male ☐ Female | Social Security No. | Birth State/Country | |

### CHILD INFORMATION: If additional space is needed, please attach a separate sheet of paper.

| | | | | |
|---|---|---|---|---|
| Child's Legal Name | *First, Middle, Last* | Relationship to Applicant | ☐ Male ☐ Female | Date of Birth *(MM/DD/YYYY)* / / |
| Child's Legal Name | *First, Middle, Last* | Relationship to Applicant | ☐ Male ☐ Female | Date of Birth *(MM/DD/YYYY)* / / |
| Child's Legal Name | *First, Middle, Last* | Relationship to Applicant | ☐ Male ☐ Female | Date of Birth *(MM/DD/YYYY)* / / |
| Child's Legal Name | *First, Middle, Last* | Relationship to Applicant | ☐ Male ☐ Female | Date of Birth *(MM/DD/YYYY)* / / |

## B. Voluntary Benefit Election

Completion of a Statement of Health and/or Statement of Insurability form may be required for coverage to be approved.

**Note: Coverage is for new elections only. Existing coverage will remain in force unless cancelled by You. Coverage not elected will be considered refused even if not specifically declined.**

### CRITICAL ILLNESS

| Product Type | Benefit Packages | Benefit Amount | Optional Riders | Insured Options |
|---|---|---|---|---|
| ☐ Critical Illness | ☐ Tier 1<br>☐ Tier 2<br>☐ Prime | Applicant Benefit Amount<br>$ ____________ | ☐ Cardiopulmonary Rider<br>☐ Childhood Critical Illness Rider*<br>☐ Genetic Screening Test Rider*<br>☐ Health Screening Rider<br>☐ Increasing Benefit Rider*<br>☐ Specified Disease Rider*<br>☐ Other *(specify)* ____________<br>**Not available with Prime Benefit Package* | ☐ Applicant Only<br>☐ Applicant/Spouse<br>☐ Applicant/Child<br>☐ Family |

Applicant's Name ______________________________

## B. Voluntary Benefit Election Continued.

### ACCIDENT EXPENSE

| Product Type | Plans | Benefit Packages | Optional Riders | Insured Options |
|---|---|---|---|---|
| ☐ Accident Expense | ☐ 24-hour Accident Expense<br>☐ Off-the-Job Accident Expense | ☐ Tier 1<br>☐ Tier 2<br>☐ Tier 3<br>☐ Tier 4<br>☐ Prime | ☐ Accident-Only Disability Income Rider<br>Benefit Period: ☐ 6-month ☐ 12-month<br>Benefit Amount: ☐ $600 ☐ $1,200<br>☐ Hospital Sickness Rider<br>☐ Tier 1 ☐ Tier 2<br>☐ Outpatient Care Rider<br>☐ Other *(specify)* ____________ | ☐ Applicant Only<br>☐ Applicant/Spouse<br>☐ Applicant/Child<br>☐ Family |

### SHORT TERM DISABILITY INCOME

| Policy Type | Benefit Packages | Benefit Options | Optional Riders |
|---|---|---|---|
| ☐ Off-the-job Accident and Sickness Disability Income<br>☐ 24-Hour Accident and Sickness Disability Income<br>☐ Off-the-job Accident-only Disability Income<br>☐ 24-Hour Accident-only Disability Income | ☐ Tier 1<br>☐ 13-week benefit period<br>☐ 26-week benefit period<br>☐ 52-week benefit period<br>☐ 104-week benefit period<br>☐ Tier 2<br>☐ 13-week benefit period<br>☐ 26-week benefit period<br>☐ 52-week benefit period<br>☐ 104-week benefit period<br>☐ Prime<br>☐ 13-week benefit period<br>☐ 26-week benefit period | Weekly Benefit Amount<br>$ ____________ | ☐ Child Care Rider*<br>☐ Child Education Rider+<br>☐ Family Medical Leave Rider*<br>☐ Infectious and Contagious Disease Rider*<br>** Not available with Prime Benefit Package*<br>*+ Only available with Tier 2 Benefit Package* |

| Elimination Period Options | | | | | | |
|---|---|---|---|---|---|---|
| Accident/Sickness Elimination: | ☐ 0/7 days | ☐ 7/7 days | ☐ 0/14 days | ☐ 7/14 days | ☐ 14/14 days | ☐ 30/30 days |
| Accident-only Elimination: | ☐ 0 days | ☐ 7 days | ☐ 14 days | ☐ 30 days | | |

**B. Voluntary Benefit Election** Continued.

**CANCER EXPENSE**

| Product Type | Benefit Options | Optional Riders | Insured Options |
|---|---|---|---|
| ☐ Cancer Expense | Radiation Chemotherapy<br>☐ $2,500 monthly / $10,000 annually<br>☐ $2,500 monthly / $15,000 annually<br>☐ $5,000 monthly / $20,000 annually<br>Hospital Confinement<br>☐ $150 ☐ $250 ☐ $350 | ☐ Cancer First Occurrence Benefit Rider<br>☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000<br>☐ Cancer First Occurrence Increasing Benefit Rider<br>☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000<br>☐ Intensive Care Unit Benefit Rider<br>☐ $300 ☐ $600<br>☐ Specified Disease Benefit Rider<br>☐ Other *(specify)* ______________ | ☐ Applicant Only<br>☐ Applicant/Spouse<br>☐ Applicant/Child<br>☐ Family |

**HOSPITAL INDEMNITY**

| Benefit Packages | Policy Type | Benefit Options | Optional Riders | Insured Options |
|---|---|---|---|---|
| ☐ Tier 1<br>☐ Tier 2<br>☐ Tier 3 | ☐ Hospital Indemnity Admission<br>☐ $1,000<br>☐ $1,500<br>☐ $2,000<br>☐ Hospital Indemnity Admission Plus<br>*(Days 1 and 2, $500; Days 3-6, $1,000)* | Hospital Confinement<br>☐ $100<br>☐ $150<br>☐ $200 | ☐ Critical Illness Rider<br>☐ Drug and Alcohol Rehabilitation Rider<br>☐ Extended Care Rider<br>☐ Genetic Screening Test Rider<br>☐ Mental and Nervous Disorder Rider<br>☐ Outpatient Accident Rider<br>☐ Outpatient Sickness Rider<br>☐ Preventive Care Rider<br>☐ Supportive Care Rider<br>☐ Surgical Rider<br>☐ Waiver of Premium Rider | ☐ Applicant Only<br>☐ Applicant/Spouse<br>☐ Applicant/Child<br>☐ Family |

| Benefit Package | Policy Type | Critical Illness Rider Benefit Options | Insured Options |
|---|---|---|---|
| ☐ Basic Care | ☐ Hospital Indemnity Admission<br>☐ $1,000 ☐ $1,500 ☐ $2,000<br>☐ Hospital Indemnity Admission Plus<br>*(Days 1 and 2, $500; Days 3-6, $1,000)* | ☐ $5,000<br>☐ $10,000 | ☐ Applicant Only<br>☐ Applicant/Spouse<br>☐ Applicant/Child<br>☐ Family |

| Benefit Packages | Optional Riders | Insured Options |
|---|---|---|
| ☐ Prime<br>☐ Sickness Only | ☐ Preventive Care Rider | ☐ Applicant Only<br>☐ Applicant/Spouse<br>☐ Applicant/Child<br>☐ Family |

| Benefit Packages | Insured Options |
|---|---|
| ☐ Flexible | ☐ Applicant Only<br>☐ Applicant/Spouse<br>☐ Applicant/Child<br>☐ Family |

Applicant's Name ______________________________

**B. Voluntary Benefit Election** Continued.

**CONTINGENT OWNER**

| Legal Name *First* *Middle* *Last* | Relationship to Insured |
|---|---|

**WHOLE LIFE COVERAGE**

| **Insured Option and Certificate Face Amount** | **Optional Riders — Some riders may not be available in all states.** |
|---|---|
| ☐ Applicant $ ____________<br>☐ Spouse $ ____________<br>☐ Child $ ____________ | ☐ Children's Term Rider<br>(*All children insured receive the same amount of coverage.)*<br>☐ $5,000<br>☐ $10,000<br>☐ Level Term Insurance Rider<br>$____________ |

Applicant's Name ______________________

## C. Beneficiaries

Unless shown differently below, survivors share equally. If additional space is needed, attach a separate sheet of paper.

### Applicant Beneficiaries

| Legal Name *(First, Middle, Last)* | Relationship | P=Primary C=Contingent | Date of Birth | Social Security No. | Share % |
|---|---|---|---|---|---|
| | | | / / | | |
| | | | / / | | |

### Spouse Beneficiaries

| Legal Name *(First, Middle, Last)* | Relationship | P=Primary C=Contingent | Date of Birth | Social Security No. | Share % |
|---|---|---|---|---|---|
| | | | / / | | |
| | | | / / | | |

## D. Certification and Authorization

I certify that the statements and answers provided in this enrollment form were made by me, are complete and true, and have been correctly and fully recorded. I agree that this enrollment form constitutes my application and shall form a part of the certificate if attached thereto. My statements and answers are offered as an inducement to grant insurance, and I understand that Assurity may use misstatements or misrepresentations in the application to contest the validity of any coverage provided. I understand that any premiums deducted before the issue date of the certificate are pre-paid premiums and will be applied to coverage beginning on the issue date. If the certificate is not issued, Assurity will refund any premium deductions it receives. I further authorize my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested *(including dependents' coverage)*.

**For Health Products Only:** I further understand that the insurance applied for shall be in force as of the certificate issue date shown on the certificate schedule and not the date the application is signed.

**For Life Products Only:** Coverage issued on this enrollment form for any person starts on the date of this enrollment, ONLY IF that person is insurable on that date, at Assurity's standard rates according to its underwriting practices, for the amount of life insurance and any additional benefits applied for.

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

Signature of Primary Proposed Insured ______________________ on ____/____/____

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# Worksite Group Statement of Health

**PLEASE PRINT WITH BLACK INK**

| Employee's Legal Name *First, Middle, Last* | | | Spouse's Legal Name *First, Middle, Last* |
|---|---|---|---|
| Employer Name | Employee: Height ft. in. Weight lbs. | | Spouse: Height ft. in. Weight lbs. |

## GENERAL

1. Has any Proposed Insured **ever** been diagnosed or 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

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

## DISABILITY INCOME

1. During the past **6 months**, has any Proposed Insured missed work for more than 5 consecutive days due to personal injury or illness *(except pregnancy)*? ☐ Yes ☐ No
2. **During the past 12 months,** has the Proposed Insured been advised to have surgery, treatment or testing which has not been completed or for which results have not been received? ☐ Yes ☐ No
3. Has the Proposed Insured **ever** had or been advised to have an organ or tissue transplant, or consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, any of the following: disease or disorder of the heart (including heart attack, heart condition, congestive heart failure, heart valve disorder), circulatory system (including peripheral vascular disease, carotid artery disease), kidneys, liver (excluding hepatitis A), lungs or respiratory system (including emphysema, chronic obstructive pulmonary disease (COPD), asthma (requiring steroids), sleep apnea); Alzheimer's disease; dementia; high blood pressure with reading of 160/100 or higher; insulin dependent diabetes; Hodgkin's lymphoma (formerly known as Hodgkin's disease); internal cancer; leukemia; lymphoma; melanoma; multiple sclerosis (MS); muscular dystrophy (MD); systemic lupus erythematosus (SLE); stroke; or transient ischemic attack (TIA or mini-stroke)? ☐ Yes ☐ No
4. During the past **5 years**, has the Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, any of the following:
   a. Mental or nervous system disorder, depression, chest pain, or disease or disorders of the joints, muscles, or spine? ☐ Yes ☐ No
   b. Carpal tunnel syndrome, chronic fatigue, fibromyalgia, or lupus? ☐ Yes ☐ No
   c. Alcoholism, drug addiction or other substance abuse, or had a positive test for an illegal drug? ☐ Yes ☐ No
   d. Any disease or disorder of the stomach, intestines, bowel, rectum, pancreas, thyroid, or urinary system? ☐ Yes ☐ No

**If YES** to any of the questions above, please provide complete details below. If additional space is needed, attach a separate piece of paper.

| Proposed Insured's Name | Date of Condition | Details *(including medical care provider's name)* |
|---|---|---|
| | | |

## CANCER EXPENSE

1. During the past **5 years**, has any Proposed Insured been advised by a medical professional to have any diagnostic tests related to cancer that have not been completed or for which results have not been received? ☐ Yes ☐ No

**If YES**, please provide complete details below. If additional space is needed, attach a separate piece of paper.

| Proposed Insured's Name | Date of Condition | Details *(including medical care provider's name)* |
|---|---|---|
| | | |

2. During the past **5 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following: internal cancer, leukemia, Hodgkin's lymphoma *(formerly known as Hodgkin's disease)*, melanoma, non-melanoma skin cancer, malignant tumors or carcinoma in situ? ☐ Yes ☐ No

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

3. **If applying for the Specified Disease Benefit Rider:** During the past **10 years**, has any Proposed Insured consulted with or been diagnosed, treated or hospitalized by a medical professional for, or had symptoms of any of the following diseases: Addison's disease, amyotrophic lateral sclerosis *(ALS or Lou Gehrig's disease)*, botulism, brucellosis, bubonic plague, Budd-Chiari syndrome, cerebral palsy, cholera, cystic fibrosis, diphtheria, encephalitis, Hansen's disease, hepatitis *(chronic B or C with liver failure)*, histoplasmosis, Huntington's chorea, Legionnaires' disease, mad cow disease, malaria, meningitis, multiple sclerosis *(MS)*, muscular dystrophy *(MD)*, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, primary biliary cirrhosis, primary sclerosing cholangitis, Q fever, rabies, Reye's syndrome, rheumatic fever, Rocky Mountain spotted fever, scarlet fever, scleroderma, sickle cell anemia, small pox, systemic lupus erythematosus, Tay-Sachs disease, tetanus, thalassemia, toxic epidermal necrolysis *(TEN)*, toxic shock syndrome, trichinosis, tuberculosis, tularemia, typhoid fever, whooping cough or yellow fever? ☐ Yes ☐ No

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

4. **If applying for the Intensive Care Unit Benefit Rider:** During the past **10 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following: disease or disorder of the heart *(including heart attack, heart condition, heart valve disorder)*, high blood pressure with reading of 160/100 or higher, stroke or insulin-dependent diabetes? ☐ Yes ☐ No

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

## CRITICAL ILLNESS

1. During the past **12 months**, has any Proposed Insured been hospitalized, disabled or advised by a medical professional to have diagnostic tests or any medical or surgical procedures that have not been completed or for which results have not been received? ☐ Yes ☐ No
2. During the past **10 years**, has any Proposed Insured had or been advised to have an organ or tissue transplant, or consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following: disease or disorder of the heart *(including heart attack, heart condition, congestive heart failure, heart valve disorder, or abnormal heart rhythm)*, circulatory system *(including peripheral vascular disease, carotid artery disease)*, liver, lungs *(excluding asthma but including chronic obstructive pulmonary disease (COPD) and emphysema)*, kidneys or pancreas, stroke, transient ischemic attack *(TIA)*, insulin-dependent diabetes, bruit, aneurysm, dementia, Alzheimer's disease, paralysis, or alcohol or drug abuse? ☐ Yes ☐ No
3. During the past **6 months**, has any Proposed Insured had any blood pressure readings of 160/100 or higher? ☐ Yes ☐ No
4. During the past **10 years**, has any Proposed Insured needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing or dressing)*? ☐ Yes ☐ No

**IF BENEFITS INCLUDE COVERAGE FOR CANCER, QUESTION 5 MUST BE ANSWERED.**

5. During the past **5 years**, has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for internal cancer, leukemia, lymphoma, Hodgkin's lymphoma *(formerly known as Hodgkin's disease)*, melanoma, basal cell carcinoma, squamous cell carcinoma, malignant tumors or carcinoma in situ? ☐ Yes ☐ No

**IF APPLYING FOR ADDITIONAL CRITICAL ILLNESS RIDER, QUESTION 6 MUST BE ANSWERED.**

6. During the past **5 years**, has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following: a mental or nervous disorder, multiple sclerosis (MS), Parkinson's disease, amyotrophic lateral sclerosis *(ALS or Lou Gehrig's disease),* or loss of sight, speech or hearing? ☐ Yes ☐ No

**IF APPLYING FOR CARDIOPULMONARY RIDER, QUESTION 7 MUST BE ANSWERED.**

7. During the past **10 years**, has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for pulmonary embolism or pulmonary fibrosis? ☐ Yes ☐ No

**IF APPLYING FOR CHILDHOOD CRITICAL ILLNESS RIDER, QUESTION 8 MUST BE ANSWERED.**

8. During the past **5 years**, has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for cerebral palsy, cystic fibrosis, spina bifida, or PKU? ☐ Yes ☐ No

**IF APPLYING FOR SPECIFIED DISEASE RIDER, QUESTION 9 MUST BE ANSWERED.**

9. During the past **10 years**, has any Proposed Insured consulted with or been diagnosed, treated or hospitalized by a medical professional for any of the following: adrenal hypofunction (Addison's disease), anthrax, antibiotic resistant bacteria, botulism, brucellosis, bubonic plague, Budd-Chiari syndrome, cholera, diphtheria, encephalitis, Hansen's disease, hepatitis *(other than type A)*, histoplasmosis, Huntington's chorea, Legionnaires' disease, Lyme disease, mad cow disease, malaria, meningitis, muscular dystrophy *(MD)*, myasthenia gravis, necrotizing fasciitis, osteomyelitis, polio, primary biliary cirrhosis, primary sclerosing cholangitis (WP disease), Q fever, rabies, Reye's syndrome, rheumatic fever, Rocky Mountain spotted fever, scarlet fever, scleroderma, sepsis, sickle cell anemia, small pox, systemic lupus erythematosus, Tay-Sachs disease, tetanus, thalassemia, toxic epidermal necrolysis *(TEN)*, toxic shock syndrome, trichinosis, tuberculosis, tularemia, typhoid fever, whooping cough or yellow fever? ☐ Yes ☐ No

**If YES** to any of the questions above, please provide complete details below. If additional space is needed, attach a separate piece of paper.

| Proposed Insured's Name | Date of Condition | Details *(including medical care provider's name)* |
|---|---|---|
| | | |

## HOSPITAL INDEMNITY

1. Currently or during the past **12 months**, has any Proposed Insured: been hospitalized two or more times, or been hospitalized for five or more days; been advised by a medical professional to be hospitalized or to have any medical or surgical procedures or diagnostic tests performed that have not been completed or for which results have not been received; undergone evaluation following abnormal test results or received treatment in a skilled nursing facility; or received home health care? ☐ Yes ☐ No

   **If YES** to any of the above, please indicate which Proposed Insured(s) ______

2. During the past **12 months**, has any Proposed Insured been hospitalized or received emergency treatment for any of the following: elevated blood pressure; asthma, chronic obstructive pulmonary disease *(COPD)* or emphysema; liver disease or disorder *(excluding hepatitis A)*; Parkinson's disease; anemia; or alcohol or drug abuse? ☐ Yes ☐ No

   **If YES** to any of the above, please indicate which Proposed Insured(s) ______

3. During the past **3 years**, has any Proposed Insured been hospitalized or received treatment for any of the following: angina *(heart-related chest pain)*, heart attack, heart surgery, arrhythmia with pacemaker or congestive heart failure; cerebral vascular insufficiency, peripheral vascular disease, stroke or transient ischemic attack *(TIA/mini-stroke)*; Crohn's disease or ulcerative colitis; or multiple sclerosis? ☐ Yes ☐ No

   **If YES** to any of the above, please indicate which Proposed Insured(s) ______

4. During the past **5 years**, has any Proposed Insured been diagnosed with or treated for internal cancer or any malignancy, including but not limited to, carcinoma in situ, sarcoma, malignant melanoma, Hodgkin's lymphoma *(formerly known as Hodgkin's disease)*, leukemia, lymphoma or a malignant tumor? *(For this question only, cancer does not include basal cell or squamous cell carcinoma.)* ☐ Yes ☐ No

   **If YES** to any of the above, please indicate which Proposed Insured(s) ______

## HOSPITAL INDEMNITY — Continued.

5. Has any Proposed Insured **ever** been diagnosed with or received treatment by a medical professional for any of the following: kidney disease *(excluding kidney stones or urinary tract disorders)*; uncorrected congenital heart defect *(excluding mitral valve prolapse)*; cystic fibrosis or muscular dystrophy; systemic lupus or any other autoimmune disease; insulin-dependent diabetes diagnosed prior to age 30 or diabetes with complications, including but not limited to, retinopathy, neuropathy or nephropathy; senile dementia or Alzheimer's disease; or an organ transplant or the potential need for an organ transplant? .......................................... ☐ Yes ☐ No

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

**If any items in questions 1-5 are answered YES, the indicated Proposed Insured will not be covered under the HI policy or any HI rider.**

**IF APPLYING FOR THE CRITICAL ILLNESS RIDER, QUESTION 6 MUST BE ANSWERED.**

6. During the past **10 years**, has any Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following: disease or disorder of the heart *(including heart attack, heart condition, heart valve disorder, congestive heart failure)* or circulatory system; stroke or transient ischemic attack *(TIA)*; peripheral vascular disease; carotid artery disease; insulin-dependent diabetes; internal cancer; leukemia; lymphoma; Hodgkin's lymphoma *(formerly known as Hodgkin's disease)*; melanoma; malignant tumors or carcinoma in situ? .......................................... ☐ Yes ☐ No

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

**IF APPLYING FOR THE WAIVER OF PREMIUM RIDER, QUESTION 7 MUST BE ANSWERED.**

7. During the past **5 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following: disease or disorder of the back, neck, knees, shoulder or joints; carpal tunnel syndrome; chronic fatigue, fibromyalgia; lupus; or asthma *(requiring steroids)*? .......................................... ☐ Yes ☐ No

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

**IF APPLYING FOR THE DRUG AND ALCOHOL REHABILITATION RIDER, QUESTION 8 MUST BE ANSWERED.**

8. During the past **5 years**, has any Proposed Insured been advised to seek treatment, or been a patient in any dependency, halfway house or other medical facility? .......................................... ☐ Yes ☐ No

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

**IF APPLYING FOR THE MENTAL AND NERVOUS DISORDER RIDER, QUESTION 9 MUST BE ANSWERED.**

9. During the past **5 years**, has any Proposed Insured been advised to seek treatment, consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for anxiety, depression, eating disorders or any other psychological or emotional disorder? .......................................... ☐ Yes ☐ No

**If YES** to any of the above, please indicate which Proposed Insured(s) ______________________

## PROPOSED INSURED'S AGREEMENT

I, the Proposed Insured, agree that all answers and statements in this application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability. I further agree that this statement of health form constitutes a part of my application and shall form a part of the certificate if attached thereto.

I understand Assurity Life Insurance Company and/or its authorized representatives may obtain medical and other information in order to evaluate my application for insurance. Some information may come from me, and some may come from other sources. I hereby authorize MIB Inc. (the Medical Information Bureau) to furnish information regarding me or my health to Assurity. I authorize Assurity to release information to MIB Inc. I know that I may request a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I have also received a copy of the MIB Notice. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I agree that this authorization shall be valid for two years from the date shown below.

**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.**

Signed at ______________________ on ______________________

*City* *State* *Date (MM/DD/YYYY)*

______________________ ______________________

*Signature of Primary Proposed Insured* *Signature of Spouse (if Proposed Insured)*

**Assurity® Life Insurance Company**
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402-476-6500 | 800-276-7619 | FAX 877-864-6630

# Worksite Group Statement of Insurability

**PLEASE PRINT WITH BLACK INK**

## PARTICIPANT INFORMATION

| Applicant's Legal Name *First, Middle, Last* | Spouse's Legal Name *First, Middle, Last* |
|---|---|
| Employer Name | |

## ADDITIONAL REQUIRED CHILD INFORMATION
If additional space is needed, please attach a separate sheet of paper.

| Child's Legal Name *First, Middle, Last* | Social Security Number | Birth State/Country |
|---|---|---|
| Child's Legal Name *First, Middle, Last* | Social Security Number | Birth State/Country |
| Child's Legal Name *First, Middle, Last* | Social Security Number | Birth State/Country |

## A. FOR CONDITIONAL GUARANTEED ISSUE, please have Spouse and Child(ren) answer the following questions.

| | Child Answer | Spouse Answer |
|---|---|---|
| 1. During the past 12 months, has any Proposed Insured missed more than five consecutive days of work or been unable to perform any primary occupation duties other than for normal pregnancy? Or, if not employed, is any proposed Insured not physically or mentally capable of full-time employment or performing the activities of a person of similar age? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. During the past 2 years, has any Proposed Insured been diagnosed, treated, hospitalized, or prescribed medication for any of the following: disease or disorder of the heart, lung, kidney, liver, or nervous system; stroke; cancer; HIV or AIDS; organ transplant; or, drug or alcohol abuse, including addiction? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If YES** to any of the questions above, please provide complete details below. If additional space is needed, attach a separate piece of paper.

| Proposed Insured's Name | Date of Condition | Details *(including medical care provider's name)* |
|---|---|---|
| | | |

## B. FOR SIMPLIFIED ISSUE, please have Applicant and Spouse answer the following questions. Spouse must answer sections A and B.

| | Applicant Answer | Spouse Answer |
|---|---|---|
| 1. During the past **12 months**, has any Proposed Insured been hospitalized, disabled or advised by a medical professional to have diagnostic tests *(excluding tests related to the AIDS virus)* or any medical or surgical procedures that have not been completed or for which results have not been received? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. During the past **2 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for disease or disorder of any of the following: circulatory system, liver, lungs *(including emphysema, chronic obstructive lung or pulmonary disease)* or kidneys; hepatitis *(other than type A)*; dizziness; Hodgkin's lymphoma *(formerly known as Hodgkin's disease)*, leukemia; dementia; multiple sclerosis; or muscular dystrophy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. During the past **6 months**, has any Proposed Insured had any blood pressure readings of 160/100 or higher which were taken by a medical professional? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. During the past **5 years**, has any Proposed Insured been treated or been advised to receive treatment for alcohol or drug use, or used illegal or controlled substances not prescribed by a physician? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. During the past **5 years**, has any Proposed Insured had their driver's license suspended or revoked, or been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence *(DUI/DWI)*? If YES, please provide name(s) of person(s) below. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. Has any Proposed Insured been diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)* or AIDS-related complex *(ARC)*; or had a positive test for human immunodeficiency virus *(HIV)* antibodies? If YES, please provide name(s) of person(s) below. | ☐ Yes ☐ No | |

| 7. Applicant: Height ft. in. Weight lbs. | Spouse: Height ft. in. Weight lbs. |
|---|---|

**If YES** to any of the questions above, please provide complete details below where applicable. If additional space is needed, attach a separate piece of paper.

| Proposed Insured's Name | Date of Condition | Details *(including medical care provider's name)* |
|---|---|---|
| | | |

## PROPOSED INSURED'S AGREEMENT

I, the Proposed Insured, agree that all answers and statements in this application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability. I further agree that this statement of insurability form constitutes a part of my application and shall form a part of the certificate if attached thereto.

I understand Assurity Life Insurance Company and/or its authorized representatives may obtain medical and other information in order to evaluate my application for insurance. Some information may come from me, and some may come from other sources. I hereby authorize MIB Inc. *(the Medical Information Bureau)* to furnish information regarding me or my health to Assurity. I authorize Assurity to release information to MIB Inc. I know that I may request a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I have also received a copy of the MIB Notice. I understand that I have the right to revoke this authorization at any time by providing written notice to Assurity. I agree that this authorization shall be valid for two years from the date shown below.

**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.**

Signed at ______________________________ on ______________________________

*City* *State* *Date (MM/DD/YYYY)*

______________________________ ______________________________

*Signature of Primary Proposed Insured* *Signature of Spouse (if Proposed Insured)*