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

Application for Individual DISABILITY INCOME INSURANCE

PLEASE PRINT WITH BLUE OR BLACK INK

1. PROPOSED INSURED

	First	Middle	Last	(MM/DD/YYYY)
Legal Name / Date of Birth	Logan	William	Carter, III	12 / 27 / 1969

Social Security No. 168-58-3680 ☒ Male ☐ Female Email lwillcar3@gmail.com Age 49

	Street Address	City	State	ZIP+4
Home Address	142 36th St NE	Washington	DC	20019

Personal Phone No. (202) 267-0535 Birth State/Country Pa. Height 5 ft. 9 in. Weight 250 lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☒ No

If YES, please list type n/a Amount per day n/a Last date of use *(MM/DD/YYYY)* / /

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

If the Proposed Insured has permanent resident status, please list permanent resident *(green card)* number. n/a

If not a United States citizen, how long has the Proposed Insured been in the United States? n/a

Does the Proposed Insured have a valid driver's license? ☒ Yes ☐ No If YES, please list state of issue and number. DC 2544838

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☒ Yes ☐ No Length of employment *Years* 5 *Months* 0

		Street Address	City	State	ZIP+4
Primary Employer	self				
Employer's Address		142 36th st NE	Washington	DC	20019

	Occupation	Duties
Full-time Employment	barber	cutting hair
Part-time Employment		

Gross annual income $ 40,000 If self-employed, net annual income $ 40,000

Unearned annual income *(interest, dividends, net rental income, etc.)* $ 0

Is the Proposed Insured an owner of a business or practice? ..... ☒ Yes ☐ No

If YES, please provide how the business is organized *(corporation, partnership, etc.)* sole proprietor

Length of Ownership 5 years Percentage of Ownership 100 Number of Employees 0

2. BENEFICIARIES

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
Maryam Ahmad	wife	217-23-1843	02 / 22 / 1974	100
			/ /	

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

3. PREMIUM PAYMENT

What amount was collected with this application? $ 0

Please indicate preference for payment type and billing frequency below:

Type
☒ Direct Billing ☐ Automatic Bank Withdrawal
☐ List Billing *(employer)*

Frequency
☐ Annual ☐ Semi-Annual ☒ Quarterly
☐ Monthly *(not available with Direct Billing)*

	First	Middle	Last	Street Address	City	State	ZIP+4
Payor Name	Logan	William	Carter, III				
Billing Address				142 36th St NE	Washington	DC	20019

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or have they entered into a written agreement to become a member of the military or National Guard? ☐ Yes ■ No

   If YES, please explain n/a

2. Has the Proposed Insured:

   a. **Ever** flown, or during the next **12 months** intend to fly, as a pilot, crew member or student? ..... ☐ Yes ■ No

   b. **Ever** participated in, or in the next **12 months** intend to participate in, any of the following hazardous sports 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

3. During the next **2 years**, does the Proposed Insured intend residence or travel outside of the United States? ..... ☐ Yes ■ No

   If YES, please explain n/a

4. During the past **12 months**, has the Proposed Insured had a change in weight of more than 10 pounds? ..... ☐ Yes ■ No

   If YES, please list Proposed Insured's name, amount of weight change and details of the change:

   n/a

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

   a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? ..... ☐ Yes ■ No

   If YES, please explain n/a

   b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ..... ☐ Yes ■ No

   If YES, please explain n/a

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

   If YES, please explain n/a

7. During the past **5 years**, has the Proposed Insured had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence (DUI/DWI), or pled guilty or been convicted of more than 3 moving violations? ..... ☐ Yes ■ No

   If YES, please explain n/a

8. During the past **10 years**, has the Proposed Insured been convicted of a felony or misdemeanor? ..... ☐ Yes ■ No

   If YES, please explain n/a

9. Has the Proposed Insured ever filed for personal or business bankruptcy? ..... ☐ Yes ■ No

   If YES, list the date(s) n/a Have all bankruptcies been discharged? ☐ Yes ☐ No If YES, list the date(s) _____

10. a. Is other disability insurance coverage in force for the Proposed Insured? ..... ☐ Yes ■ No

    If YES, please provide details below.

    b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ..... ☐ Yes ■ No

Company Name	Policy No.	Individual (I) Group (G)	Benefits *(monthly benefit and benefit period)*	Issue Date *(MM/DD/YYYY)*	Replacing, modifying or borrowing against?	Coordinates w/ Soc. Sec.?	Employer Paid?
n/a	n/a	☐ I ☐ G	n/a	/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

HEALTH SECTION

Please answer the following questions. If YES to any of the following, please provide details on page 4.

1. During the past **10 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. Heart disorder, including a heart attack *(myocardial infarction)*, angina, irregular heartbeat or abnormal heart rhythm *(arrhythmia)*, chest pain, hypertension *(high blood pressure)*, heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke or transient ischemic attack *(TIA or mini-stroke)*, or rheumatic fever? ☐ Yes ■ No

   b. 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)*, protein or blood in the urine, Crohn's disease, ulcerative colitis, disease or disorder of the stomach, gall bladder, thyroid, bladder or prostate, other intestinal or digestive tract disease, or pancreatitis? ☐ Yes ■ No

   c. Internal cancer or tumor, cyst, melanoma, lymphoma, leukemia, disorder of lymph nodes or any glandular disorder? ☐ Yes ■ No

   d. 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? ☐ Yes ■ No

   e. Sleep apnea, cystic fibrosis, emphysema or chronic obstructive pulmonary disease *(COPD)*, shortness of breath, asthma or other respiratory disorder, rheumatoid arthritis, paralysis or connective tissue disorder *(e.g. lupus or scleroderma)*? ☐ Yes ■ No

   f. Dizziness, headaches, migraines, fainting spells, anxiety, depression, eating disorders or any other psychological or emotional disorder? ☐ Yes ■ No

   g. Arthritis, rheumatism or any disease or disorder of the back, spine, bones, joints or muscles? ☐ Yes ■ No

   h. Varicose veins, varicose ulcer or phlebitis, syphilis or a hernia? ☐ Yes ■ No

   i. Any disease or disorder of the eyes, ears, nose or throat? ☐ Yes ■ No

2. During the past **10 years**, has the Proposed Insured:

   a. Used controlled substances such as cocaine, heroin, amphetamines, barbiturates, hallucinogens or any other controlled substance not prescribed by a physician? ☐ Yes ■ No

   b. Been treated by a physician, or advised by a physician to seek treatment, for drug or alcohol use? ☐ Yes ■ No

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

   a. Been a patient in any hospital, clinic, dependency program, halfway house or other medical facility? ☐ Yes ■ No

   b. 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 results have not been received? ☐ Yes ■ No

   c. Had any special examinations or laboratory tests such as X-rays, electrocardiograms, blood tests *(other than AIDS-related blood tests)* or urine tests? ■ Yes ☐ No

   d. Consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any other illness or injury requiring medical attention or blood transfusions? ☐ Yes ■ No

4. During the past **10 years**, has the Proposed Insured 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

5. Has the Proposed Insured had a natural parent or sibling who was diagnosed by a medical professional with or died of cancer, heart disease or diabetes prior to the age of 60? If YES, please identify family member, relationship to Proposed Insured, disorder and age at death. ☐ Yes ■ No

6. a. During the past **10 years**, has the Proposed Insured had any disorder of any genital or reproductive organ, or had a miscarriage, stillbirth or Caesarean section? ☐ Yes ■ No

   b. Is the Proposed Insured currently pregnant? ☐ Yes ■ No

   If YES, date child is expected *(MM/DD/YYYY)* ___/___/____

DETAILS: Enter complete details from questions #1-6 on page 4. If more space is needed, attach additional Supplemental Information form.

SUPPLEMENTAL INFORMATION

Question #/Letter	Name (First, Middle, Last)	Onset Date (MM/DD/YYYY)	Duration (Days, Mos, Yrs)	Health Condition and Details	Medical Care Provider's Name/Address/Phone
3c	Logan Carter, III	/ /		blood work for physical exam	Shanique Lankford, 4 Atlantic St. SW Washington DC (202) 407-7747
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Additional Information:

DISABILITY INCOME PRODUCT SECTION

Please complete for Individual Disability Income and/or Business Overhead Expense Disability Income.

INDIVIDUAL DISABILITY INCOME

Monthly Base Amount $ 2500 Occupation Class: ☐ 4 A ☐ 3 A ■ 2 A ☐ 1 A

Elimination Period: ☐ 30 days ☐ 60 days ■ 90 days ☐ 180 days ☐ 365 days

Benefit Period: ☐ 1 Year ☐ 2 Years ☐ 5 Years ☐ 10 Years ☐ To age 65 ■ To age 67

ADDITIONAL BENEFITS *(If available)*

Check benefit(s) desired and indicate amount requested.

☐ Supplemental Disability Income Rider $ _____

☐ Critical Illness Benefit Rider $ _____

☐ Retroactive Injury Benefit Rider

☐ Guaranteed Insurability Rider

☐ Automatic Benefit Increase Rider

☐ Non-Cancelable Rider

☐ Return of Premium Benefit Rider

☐ Own Occupation Rider *(select desired Benefit Period)*

- ☐ 5-Year *(not available with 1 or 2-Year Benefit Period)*
- ☐ 10-Year *(available with 10-Year Benefit Period)*
- ☐ To Age 65 *(available with To Age 65 Benefit Period)*
- ☐ To Age 67 *(available with To Age 67 Benefit Period)*

☐ Residual Disability Benefit Rider *(select desired Benefit Period)*

- ☐ Rider Benefit Period matches Base Policy
- ☐ 5-Year Rider Benefit Period *(Not available with 1-year or 2-year Base Benefit Periods)*

☐ Catastrophic Disability Benefit Rider *(select desired Benefit Period)*

Available with 1-Year Base Benefit Period: ☐ 4-Year Rider Benefit Period OR ☐ 9-Year Rider Benefit Period

Available with 2-Year Base Benefit Period: ☐ 3-Year Rider Benefit Period OR ☐ 8-Year Rider Benefit Period OR ☐ To Age 65 Benefit Period

Available with 5-Year Base Benefit Period: ☐ 5-Year Rider Benefit Period OR ☐ To Age 65 Benefit Period

Available with 10-Year Base Benefit Period: ☐ To Age 65 Benefit Period

BUSINESS OVERHEAD EXPENSE DISABILITY INCOME

Monthly Base Amount $ n/a Occupation Class: ☐ 4 A ☐ 3 A ☐ 2 A

Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days

Benefit Period: ☐ 1 Year ☐ 2 Years

Average monthly expenses currently incurred, for which the Proposed Insured is liable:

Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
Employees' salaries	$	Accounting fees	$
Utilities *(electricity, gas, water, telephone)*	$	Property/payroll taxes	$
Business space *(rent/mortgage payment)*	$	Other eligible expenses *(Please list)*	
Furniture/equipment payments *(lease or principal)*	$		$
Laundry, office maintenance	$		$
Business insurance premiums	$		$
		Total Monthly Expenses	$

PHYSICIAN INFORMATION

Please list the last physician consulted within the last 10 years:

Name Shanique Lankford Date last consulted 11 /20 /2017 (MM/DD/YYYY)

Address 4 Atlantic St. SW
Street Address *Suite*

Washington DC
City *State* *ZIP+4*

Phone No. ( ) (202) 407-7747 Fax No. ( )

Is this your primary physician? ☒ Yes ☐ No

Reason for consultation routine physical

Results nothing abnormal, no prescriptions

AGREEMENT

I *(We)* have read the above questions and answers and declare that they are complete and true to the best of my *(our)* knowledge and belief. I *(We)* agree that this application shall form a part of the policy if attached thereto.

I *(We)* agree that:

a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.

b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and the answers on the application remain true, complete and accurate as of the date the first full premium is paid. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.

c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Substitute Form W-9 information *(Request for Taxpayer Identification Number and Certification)*: I, the Owner *(or each Joint Owner)*, 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 Lanham MD on 03 /24 /2019
City *State* *Date (MM/DD/YYYY)*

DocuSigned by: Logan Carter D37B8E1A6527448...
Signature of Proposed Insured

DocuSigned by: TaNoah Morgan F5BE5C05BBA640D...
Signature of Licensed Agent

TaNoah Morgan, pending
Print Agent Name and Agent No.

AGENT STATEMENT

1. a. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ■ No

   b. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ■ Yes ☐ No

2. a. Did you personally see each Proposed Insured on the date of application? ■ Yes ☐ No

   b. How well do you know the Proposed Insured(s)? ■ Well ☐ Slightly ☐ Not at all

   c. Did the Proposed Insured approach you to purchase insurance? If YES, list their stated need for the insurance_____ ■ Yes ☐ No

   d. Did the Proposed Insured(s) directly respond to you regarding each application question? ■ Yes ☐ No

   e. Was a government-issued picture ID requested and reviewed for the Proposed Insured, Owner and Payor? ■ Yes ☐ No

   f. Was each Proposed Insured present, and did you witness their signatures at the time the application was taken? ☐ Yes ■ No

   g. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured(s)? If YES, please provide details below. ☐ Yes ■ No

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ■ Yes ☐ No

   Agent is responsible for scheduling exam items.

   NOTE: ANY PREFERRED PLANS REQUIRE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.

   ☐ Paramedical examination ☐ Blood sample ☐ Urine sample ☐ Electrocardiogram *(EKG)* ☐ Medical exam by physician

4. Is other insurance coverage in force for any Proposed Insured? ■ Yes ☐ No

5. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ■ No

6. Was sales material used in soliciting this application? ☐ Yes ■ No

7. Was the sales material left with the applicant? ☐ Yes ■ No

8. Was the sales material approved by Assurity Life Insurance Company? ☐ Yes ■ No

9. Are commissions to be split? ☐ Yes ■ No Agent Name TaNoah Morgan Agent's No. pending 100 %

   Agent Name _____ Agent's No. _____ %

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.

☐ Add to existing bank withdrawal—indicate other applicant and/or policy numbers _____

LIST BILL

☐ Set up NEW list bill—submit signed employer authorization form with the application.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

Where applicable, I acknowledge that an Outline of Coverage was provided to the Proposed Insured at the time this application for insurance was taken.

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.

DocuSigned by: TaNoah Morgan F5BE5C05BBA640D...

Signature of Soliciting Agent

03 / 24 / 2019

Date (MM/DD/YYYY)

(240) 544-6800 / (240) 544-6800

Business Phone No. and Fax No.

TaNoah Morgan

Soliciting Agent's Printed Name

pending

Agent No.

tmorgan@msagencies.com

Agent's E-mail

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

Confidential Information Authorization

Logan William Carter III — 12 / 27 / 2019
Legal Name of Applicant/Insured/Claimant (Please print) — ***Date of Birth** (MM/DD/YYYY)*

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

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

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

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau)*, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- 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 diagnosis and treatment for alcohol, drug and tobacco use, and mental illness. Excluded are psychotherapy notes, but included are medication prescription and monitoring, counseling sessions *(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.
- Financial records and information.

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

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, MIB Inc., 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 redisclosure 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.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twenty-four *(24)* months from the date of signature below ***(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.

03/24/2019 / / — DocuSigned by: Logan Carter D3788E1A4527448...
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)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

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

Confidential Information Authorization for Release of Psychotherapy Notes

Logan William Carter III — 12 / 27 / 2019
Legal Name of Applicant/Insured/Claimant (Please print) — ***Date of Birth*** *(MM/DD/YYYY)*

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

Applicant/Insured/Claimant: List child(ren) and date(s) of birth

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

I, on behalf of myself or the person named above *(Individual)*, hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Inc. *(formerly known as the Medical Information Bureau)*, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company *(Assurity)*, or its reinsurers, any such information. This may include:

- Psychotherapy notes

I understand that this information may be released by Assurity and/or its reinsurers to their consulting physicians, their attorneys, MIB Inc. and to other insurance companies with 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 this authorization, I further authorize Assurity, or its reinsurers, to make a brief report of my personal health information to MIB Inc.

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, MIB Inc., 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 redisclosure 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.

I further agree to execute additional documents that may be necessary to permit Assurity to obtain medical and/or financial information relevant to my application for insurance or claim for benefits, including, but not limited to, federal and/or state tax records and Social Security Administration records.

This authorization is valid for twelve *(12)* months from the date of 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.

03/24/2019 / / — DocuSigned by: Logan Carter 03788E1A4527448...
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)

ORIGINAL TO HOME OFFICE, COPY TO BE LEFT WITH APPLICANT

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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.