Assurity

Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
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; human immunodeficiency virus (*HIV*) or acquired immune deficiency syndrome (*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 acquired immune deficiency syndrome (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 may subject the individual to substantial criminal and 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)*