ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (866) 289-7337 • FAX (877) 864-6630

Worksite Individual HEALTH INSURANCE APPLICATION

PLEASE PRINT WITH BLACK INK

Entire application form must be completed for new applications and for additions or increases to existing coverage; please check the appropriate box.

☐ New application ☐ Addition or increase to existing coverage; Policy No. _____

1. PRIMARY PROPOSED INSURED

First	*Middle*	*Last*	*MM/DD/YYYY*
Legal Name			Date of Birth / /

Social Security No.	☐ Male ☐ Female	Email	Age

Street Address	*City*	*State*	*ZIP+4*
Home Address			

Personal Phone No. ( )	Birth State/Country	Height ft. in.	Weight lbs.

Primary Employer	Gross monthly income $	*MM/DD/YYYY* Full-time Hire Date / /
Title/Occupation	Duties	

2. OTHER PROPOSED INSURED—SPOUSE

First	*Middle*	*Last*	*MM/DD/YYYY*
Legal Name			Date of Birth / /

Personal Phone No. ( )	☐ Male ☐ Female	Age	Height ft. in.	Weight lbs.

3. OTHER PROPOSED INSURED—CHILD(REN) (If additional space is needed, attach a separate sheet of paper.)

Legal Name *(First, Middle, Last)*	Gender	Age	Date of Birth
	☐ Male ☐ Female		/ /
	☐ Male ☐ Female		/ /
	☐ Male ☐ Female		/ /
	☐ Male ☐ Female		/ /

4. BENEFICIARIES (If additional space is needed, attach a separate sheet of paper.)

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Date of Birth	Share %
		/ /	
		/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Date of Birth**	**Share %**
		/ /	
		/ /	

5. FOR ALL COVERAGES, please answer the following questions.

1. In the past **90 days**, have you been working less than 30 hours per week or unable to perform any of the duties of your primary occupation? ☐ Yes ☐ No

   If YES, please explain _____

2. 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, provide name(s) of person(s) _____

3. a. Does any Proposed Insured have other disability income or critical illness insurance coverage in force? ☐ Yes ☐ No
   If YES, provide details below.

   b. If this insurance is issued, will it replace or modify existing or pending coverage? ☐ Yes ☐ No
   If YES, complete any applicable State Replacement form.

Company Name	Type of Coverage	Amount of Coverage

Primary Proposed Insured's Name _____

ACCIDENT EXPENSE

Plans	Insured Options	Benefit Options	Riders	Premium Amt.
☐ 24-hour Accident Expense ☐ Off-the-job Accident Expense	☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Family	☐ 1 unit ☐ 2 units	☐ Accident-only Disability Income Rider Benefit Period: ☐ 6-month ☐ 12-month Benefit Amount: ☐ $600 ☐ $1,200 ☐ Wellness Benefit Rider ☐ Other *(specify)* _____	

HEALTH SECTION

Please answer the following question if applying for Accident-only Disability Income Rider.

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

Primary Proposed Insured's Name _____

CANCER EXPENSE

Insured Options	Benefit Options	Riders	Premium Amt.
☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Family	Radiation/Chemotherapy ☐ $2,500 monthly / $10,000 annually ☐ $2,500 monthly / $15,000 annually ☐ $5,000 monthly / $20,000 annually ☐ $5,000 monthly / $30,000 annually Hospital Confinement ☐ $150 ☐ $250 ☐ $350	☐ Cancer First Occurrence Benefit Rider ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ Cancer First Occurrence Increasing Benefit Rider ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ Intensive Care Unit Benefit Rider ☐ $300 ☐ $600 ☐ Specified Disease Benefit Rider ☐ Other *(specify)* _____	

HEALTH SECTION

Please answer the following questions.

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? **If YES, please provide complete details in #5 below.** ..... ☐ Yes ☐ No

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, identify name(s) of person(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, identify name(s) of person(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, identify name(s) of person(s) _____

5. **DETAILS:** Enter complete details from question #1 below. If additional space is needed, attach a separate sheet of paper.

Name *(First, Middle, Last)*	Relationship to Insured	Date(s) of Condition *(MM/DD/YYYY)*	Health Condition and Details	Medical Care Provider's Name/Address/Phone

Primary Proposed Insured's Name _____

PRIMARY PROPOSED INSURED'S AGREEMENT

I *(We)* agree that:

a. 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.

b. No agent is authorized or has power to change or waive any term, provision or condition of this application, or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

c. The insurance applied for shall be in force as of the policy issue date as shown on the policy schedule and not the date the application is signed. I understand that any premiums deducted before the issue date of the policy(ies) are pre-paid premiums and will be applied to coverage beginning on the issue date. If the policy(ies) is(are) not issued, Assurity will refund any premium deductions it receives.

d. If no policy is issued and delivered and no benefit is paid, all premiums paid will be returned. If the policy is issued as applied for or a policy amendment is accepted by the proposed owner, premium paid will be applied to that policy.

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.

Issue Date ____/____/____ *MM/DD/YYYY*

Signed at _____ on ____/____/____
City *State* *Date (MM/DD/YYYY)*

_____
Signature of Primary Proposed Insured

AGENT'S STATEMENT AND AGREEMENT

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

I hereby certify that I have accurately recorded in this application all information supplied by the Primary Proposed Insured. The Primary Proposed Insured has read the completed application, or has had the completed application read to them.

_____ ____/____/____ (____)_____/(____)_____
Signature of Licensed Agent *Date (MM/DD/YYYY)* *Business Phone No. and Fax No.*

_____ _____ _____
Agent's Printed Name *Agent No.* *Group No.*