ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402)476-6500 • (800)276-7619 • FAX (402)437-4591

Application for INSURANCE

PLEASE PRINT WITH BLACK INK

1. PROPOSED INSURED

Legal Name (First / Middle / Last): Billy Dean Allred
Date of Birth (MM/DD/YYYY): 02/05/1949

Social Security No. 451-84-9886 | [X] Male [ ] Female | E-Mail | Age 60

Home Address (Street Address / City / State / ZIP+4): 805 S. Commerce Kemp, TX 75143-

Personal Phone No. (469) 383-9954 | Birth State/ Country TX | Driver's Lic. No./State | Height 6 ft. 1 in. | Weight 285 lbs.

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

If YES, please list type(s): Last date of use (MM/DD/YYYY)

2. POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

Legal Name (First / Middle / Last) | Date of Birth (MM/DD/YYYY)

Social Security No. | Relationship to Insured | Birth State/Country

Home Address (Street Address / City / State / ZIP+4) | E-Mail

3. BENEFICIARIES *(If multiple Beneficiaries, please attach additional sheets)*

Primary Beneficiary Name *(First, Middle, Last)*	Relationship to Insured	Social Security No.	Date of Birth *(MM/DD/YYYY)*
Patricia Jean Allred	Wife	462-57-2932	04/12/1968
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship to Insured**	**Social Security No.**	**Date of Birth *(MM/DD/YYYY)***
Janet Michell Thompson	Sister-In-Law		10/05/1976

4. HEALTH SECTION

Section A— If any question is answered YES, coverage cannot be issued.

1. Has the Proposed Insured been medically diagnosed as having a life expectancy of **12 months** or less? [ ] Yes [X] No
2. In the past **12 months** has the Proposed Insured been diagnosed as having or been treated for uncontrolled diabetes or any complications thereof, including numbness, amputation, eye or kidney disorder, coma or insulin shock; or needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing or dressing)*; or had or been advised to have brain, heart or circulatory surgery, kidney dialysis or amputation caused by disease; or been confined to a nursing facility or received inpatient services at a medical facility 2 or more times? [ ] Yes [X] No
3. Has the Proposed Insured **ever** been diagnosed as having or been treated for *(including office visits, medication or surgery)*: leukemia, systemic lupus erythematosus *(SLE)* or amyotrophic lateral sclerosis *(ALS)*, cirrhosis, hepatitis type C, liver disease, kidney disease affecting both kidneys, dialysis, Alzheimer's disease, dementia, lymphoma or malignant melanoma; or received or been advised to receive an organ or tissue transplant; or in the past **2 years** been diagnosed as having internal cancer? [ ] Yes [X] No
4. Prior to age 25, has the Proposed Insured been diagnosed as having or received treatment for cerebral palsy, muscular dystrophy, cystic fibrosis, sickle cell anemia, Down's syndrome or congenital heart disease? [ ] Yes [X] No
5. Has the Proposed Insured had a test to detect the presence of cancer and not yet received the results, or been advised to have surgery for a heart condition or blood vessel disease, or been advised to receive medical treatment or tests that have not been completed? [ ] Yes [X] No
6. Has the Proposed Insured **ever** been medically 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 [X] No

Section B— If this question is answered YES, the Proposed Insured will be considered for the Modified Benefit Whole Life coverage only.

1. In the past **90 days** has the Proposed Insured been, or are they now, confined to a psychiatric facility or receiving home health care? [ ] Yes [X] No

Section C— Complete only if all answers in Sections A and B were NO. Any YES answers in Section C limit consideration to Graded Benefit Whole Life.

1. In the past **12 months**, has the Proposed Insured been medically diagnosed as having or been treated for: emphysema *(chronic obstructive pulmonary disease)*, congestive heart failure or cardiomyopathy, cerebral vascular accident, stroke or aneurysm, any mental or nervous disorder requiring hospitalization, or had or been advised to have treatment for any drug or alcohol abuse? [ ] Yes [X] No
2. In the past **5 years**, has the Proposed Insured had heart disease requiring bypass surgery, angioplasty or placement of vascular stents? [X] Yes [ ] No
3. Has the Proposed Insured **ever** been diagnosed as having or been treated for *(including office visits, medication or surgery)*: diabetes requiring insulin injections combined with a medical history of stroke, transient ischemic attack *(TIA)* or heart disease? [ ] Yes [X] No

If all questions in Sections A, B and C are answered NO, the Proposed Insured will be considered for Level Benefit Whole Life coverage.

5. POLICY INFORMATION

Plan of Insurance: ☐ Level Benefit Whole Life ☒ Graded Benefit Whole Life ☐ Modified Benefit Whole Life Initial Death Benefit $20,000.00

Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☒ Monthly *(Automatic Bank Withdrawal)* ☐ Monthly *(Credit Card)*

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

Does the Proposed Insured have other insurance coverage in force? .... ☒ Yes ☐ No

If YES, please provide details below, and complete and return the appropriate State Replacement Form.

Name of the company Banker's Life and Ca Policy No. ______

AGREEMENT— No agent is authorized to change or waive the terms of this Agreement.

I, the Proposed Insured, agree that to the best of my knowledge and belief:

1. All answers in this Application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability.
2. The first premium is equal to the full premium for the Premium Payment Mode selected in Section 5, "Policy Information," above. If the first premium is paid on the date this Application is signed, the insurance applied for becomes effective on that date subject to: **a.** The Company's underwriting requirements, **b.** The terms of the attached Conditional Receipt, and **c.** The terms of the policy applied for, including its suicide and contestability provisions.
3. If the first premium is not paid on the date this Application is signed, no insurance will be in effect unless: **a.** A policy is delivered to and accepted by the Owner and the entire first premium is paid during my lifetime, and **b.** At the time of such delivery, acceptance or payment, whichever is later, all information furnished in this Application remains true and complete to the best of my knowledge.

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 subject to a substantial civil penalty where and to the extent allowed by state law.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or the Medical Information Bureau, Inc., that has any records or knowledge of me or my health, to give to Assurity Life Insurance Company, or its reinsurers, any such information for use to determine eligibility for insurance or benefits under an existing policy. A photographic copy of this authorization shall be as valid as the original. **I agree** this authorization shall be valid for two years from the date shown below. **I understand** that I or my authorized representative may receive a copy of this authorization.

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

______ ______
Signature of Proposed Insured *Signature of Owner(s) (If other than Proposed Insured)*

AUTOMATIC BANK WITHDRAWAL

Type of Account: ☐ Checking ☐ Savings Applicants and/or policy numbers to be included: ______

☐ NEW—sign authorization below, attach voided check. Date of Withdrawal ___/___/___ *(MM/DD/YYYY)* ☐ Add to existing bank withdrawal on ___/___/___ *(MM/DD/YYYY)*

Date of Withdrawal *cannot be* the 29th, 30th or 31st. If no date is entered, the policy issue date will be used.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account indicated below. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account. I request the first premium be debited from my account upon policy issue: ☐ Yes ☐ No

THIS PORTION IS REPLACED WITH FORM 75-050-05055

Name of Financial Institution *Routing No. (9-digit number)* *Account No.*

______ ___/___/___ ( )______
Signature of Account Holder *Date (MM/DD/YYYY)* *Telephone No.*

FIELD UNDERWRITER'S STATEMENT

I HAVE TRULY AND ACCURATELY RECORDED in this Application the information provided by the Proposed Insured and witnessed his or her signature.

Premium of $121.19 was collected with this application.

To the best of my knowledge, if this insurance is issued, will it replace, modify or borrow against existing or pending coverage? .... ☐ Yes ☒ No

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.

______ ______ (214) 342-8588 / (214) 389-2128
Signature of Soliciting Agent *Date (MM/DD/YYYY)* *Business Phone No. and Fax No.*

PATRICIA J ALLRED 62U3 pallred@nia.biz
Soliciting Agent's Printed Name *Agent No.* *Agent's E-mail*

______ ___/___/___ ______ ( )______
Signature of Soliciting Agent *Date (MM/DD/YYYY)* *Agent No.* *Business Phone No.*

HOME OFFICE CORRECTIONS
AND ADDITIONS ONLY

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Customer Identification INFORMATION

PLEASE PRINT WITH BLACK INK

ANTI-MONEY LAUNDERING PROGRAM REQUIRES THE AGENT TO COMPLETE THIS FORM, PROVIDING THE FOLLOWING INFORMATION:

Applicant/Owner Name Billy Dean Allred   Social Security No. 451-84-9886

1. Source of Funds

- [X] Current Income
- [ ] Savings
- [ ] Another person *(if so, identify)* ____
- [ ] Proceeds of canceled life insurance policy
- [ ] From values of existing life insurance policy
- [ ] Other ____

2. Intended purpose of applied for coverage

- [X] Burial/final expenses
- [ ] Retirement
- [ ] Mortgage pay-off
- [ ] Funding a charitable contribution
- [ ] Periodic Income
- [ ] Post-death family needs
- [ ] Educational expenses
- [ ] Business need *(e.g. key-person life insurance)*
- [ ] Other ____

3. Applicant's background

- [ ] Length of time known *(in years)* 18
- [ ] Nature of relationship spouse
- [ ] How known spouse
- [ ] Applicant's occupation retired

Business relationship with applicant? [ ] Yes [X] No If so, describe ____

4. Any additional information you possess regarding the background of/your relationship with the applicant

____

____

5. Source of information

Name Billy Dean Allred

[X] Applicant [ ] Owner [ ] Payor [ ] Other *(specify)* ____

I certify all of the above information is true and correct to the extent of my knowledge and reflects the information provided to me by the applicant, except where information from me is required.

____
Producer Signature

62U3
Producer No.

PATRICIA J ALLRED
Producer Name

____
Date (MM/DD/YYYY)

Mail or fax this completed and signed form along with the application submitted to the home office.

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Life Insurance or Annuity
REPLACEMENT NOTICE

IMPORTANT NOTICE

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by withdrawal, surrender or borrowing of some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs, and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating your existing policy or contract? ☐ Yes ☒ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☒ No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing *(include the name of the insurer, the insured or annuitant, and the policy or contract number if available)* and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY NO.	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
Banker's Life and Ca		Billy Dean Allred	NA

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because:

____

I certify that the responses herein are, to the best of my knowledge, accurate:

Billy Dean Allred
Applicant's Signature and Printed Name — *Date (MM/DD/YYYY)*

PATRICIA J ALLRED
Producer's Signature and Printed Name — *Date (MM/DD/YYYY)*

Signed form to be returned to the home office.
Applicant to receive a copy of the signed form at the time the application is taken.

I do not want this notice read aloud to me.__________ *(Applicant must initial only if they do not want the notice read aloud.)*

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS

Are they affordable?

Could they change?

You're older—are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST-SENSITIVE LIFE PRODUCT

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? *(See your tax advisor.)*

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

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Automatic PREMIUM PAYMENT

Name of Proposed Insured Billy Dean Allred
First *Middle* *Last*

Date Signed ____________ *(MM/DD/YYYY)*

Policy No. *(if for an existing policy)* ____________

AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

Name of Account Holder or Authorized Officer Billy Dean Allred

☒ Initial and recurring premiums ☐ Recurring premiums only

If "Initial and recurring premiums" is marked, the company's authority to debit from your account the first premium for this insurance does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Type of Account: ☒ Checking ☐ Savings

Date of Withdrawal 28 Date ***cannot*** be the 29th, 30th or 31st. If no date is entered, the policy issue date will be used.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate debit entries to my account listed below for premiums as selected above. I understand that initiating automatic payments may result in additional drafts to bring my account current. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any debit to my account. I further understand that if the date of the withdrawal is after the policy issue date and if any premium is not honored, my policy may lapse and require evidence of insurability, according to the terms of my policy.

Citizens National Bank	111901629	110207449
Name of Financial Institution	*Routing No. (9-digit number)*	*Account No.*
Signature of Account Holder or Authorized Officer and Title	*Date (MM/DD/YYYY)*	*Telephone No.*

TO ENSURE CODING ACCURACY, SUBMIT VOIDED CHECK
(unless application is submitted electronically)

CREDIT CARD AUTHORIZATION

Name of Account Holder or Authorized Officer ____________

☐ Initial premium only ☐ Recurring premiums only ☐ Initial and recurring premiums

If "Initial premium only" or "Initial and recurring premiums" is marked, the company's authority to charge the first premium for this insurance to your credit card does not begin until the date the policy is issued. No coverage will be in force until the premium is paid.

Type of Card: ☐ MasterCard ☐ Visa ☐ Discover

Date of Charge: ☐ 1st ☐ 5th ☐ 10th ☐ 15th ☐ 20th ☐ 25th
If no date is selected, recurring charges will occur on the option date immediately prior to the policy issue date.

I hereby request and authorize Assurity Life Insurance Company, Lincoln, Nebraska, to initiate charges to my credit card listed below for premiums as selected above. I understand that initiating automatic payments may result in additional drafts to bring my account current. This authorization shall remain in effect until revoked by me in the manner provided by law. Until it receives notice of such revocation, I agree that Assurity Life Insurance Company shall be fully protected in honoring any charges to my credit card. I further understand that if the date of the withdrawal is after the policy issue date and if any premium is not honored, my policy may lapse and require evidence of insurability, according to the terms of my policy.

Name as it appears on Card (Please print)	*Card/Account No.*	*Expiration Date (MM/YYYY)*

Credit card billing address ____________
Street Address *P.O. Box* *City* *State* *Zip+4*

Signature of Account Holder or Authorized Officer and Title	*Date (MM/DD/YYYY)*	*Telephone No.*

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CONSUMER INFORMATION

Conditional Receipt

Please make **all** premium checks payable to "Assurity Life Insurance Company." Please **do not** make checks payable to the agent or leave "payee" blank.

Received from Billy Dean Allred with the attached Application to the Company the sum of $121.19 as payment of the first premium for the life insurance applied for.

a. If the first premium acknowledged by this Conditional Receipt is paid on or before the date the Application was signed; and

b. If, on the date the Application was signed, the Proposed Insured was insurable without special exception and at standard rates under the Company's underwriting rules and practices for the insurance applied for;

c. The Company agrees to insure the Proposed Insured under this Conditional Receipt. The amount of insurance hereunder will be the lesser of the amount applied for, or the amount for which the Proposed Insured qualifies, but not to exceed $25,000 for any individual applying for insurance with the Company.

This Conditional Receipt terminates the earlier of a) 60 days after the date the Application was signed, or b) the date the insurance applied for becomes effective. If one or more of the conditions are not met, the Company's liability will be limited to the return of the sum received. This Conditional Receipt is controlled by the terms of the policy applied for. No agent is authorized to change or alter this Conditional Receipt.

Agent's Signature	Agent's Printed Name	Date (MM/DD/YYYY)

THIS PORTION HAS BEEN REPLACED WITH FORM 75-652-05055

Notice of Investigative Consumer Report

Required by the Fair Credit Reporting Act

We appreciate your application for insurance and intend to process it as speedily as possible so that you can know whether it has been approved. As is customary in the business world, and as part of our normal underwriting procedure, an investigative consumer report may be obtained. These reports typically include information on a Proposed Insured's character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates. Upon written request to the Underwriting Department at the Company's address above, further information as to the nature and scope of the report will be furnished you.

Notice of Acquisition & Disclosure of Confidential Information

Required by the Medical Information Bureau *(MIB)*

Information regarding your insurability will be treated as confidential. Assurity Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number 617-426-3660.

Assurity Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Proposed Insured should retain this page in all instances.