Welcome to the

WARE GROUP
GENERAL AGENCIES

ATTENTION:

Claim forms should be mailed, faxed or emailed to:
jade@waregroupga.com
Fax: 217-954-0348
3808 W. Springfield Ave. Suite C
Champaign, IL 61822

• Attached are the Critical Illness claim forms that are required in order to file for benefit under the Critical Illness policy, you will need to fill out the attached claim form and provide the positive pathology report confirming diagnosis.

For assistance, please call:

Jade Wood

Claims Support & Office Manager
Jade@waregroupga.com
Phone: 855-535-4231 ext. 213
Fax: 217-954-0348

3808 W. Springfield Ave. Suite C
Champaign, IL. 61822

Office Hours: Mon-Thurs 8 am-4 pm, Fri 8 am-12 pm

Assurity® Filing an Assurity Critical Illness Claim

Sign up for direct deposit to receive benefits faster.

Otherwise we will mail applicable benefits directly to you.

Critical Illness insurance provides benefits when an insured person is diagnosed with a specified critical illness or undergoes a covered procedure.

This document lists the forms and evidence required for submission of a claim for benefits. Additional information may be necessary to determine benefit eligibility and may require Assurity to order medical records. The required forms listed below can be accessed in the Customer Center on **assurity.com,** in the policy owner's MyAssurity secure account, or by contacting Assurity's Claims Department at **800-869-0355 Ext. 4484.** **If the claim is for a spouse or a child 18 years of age or older, the claim will require submission by fax, email or mail.**

Proof of Claim may be required within 12 months of the time of loss. Assurity administers many different plans of insurance. Your policy may not include all of the benefits detailed below. Please consult your contract for specific benefits, definitions, provisions, limitations and exclusions.

Specified Critical Illness	Information Needed/Required Proof for Claim
Please see your policy for a list of covered conditions.	1. Critical Illness Claim form Claimant Statement #01-097-02241F – to be completed by claimant. Check the condition for which the claim is being filed. Provide the additional information requested for the condition. This form can be securely filed electronically in the policy owner's MyAssurity account. If preferred, this form may also be printed and sent to Assurity by fax, email or mail; **and** 2. Confidential Information Authorization form #75-500-05055 – to be completed by claimant. This form can be securely filed electronically in the policy owner's MyAssurity account. If preferred, this form may also be printed and sent to Assurity by fax, email or mail; **and** 3. Critical Illness Claim form Attending Physician's Statement #01-098-02241F - You will need to print this form and have the attending physician complete it; the General Information section, as well as the section for the corresponding claimed critical illness, are to be completed; the completed form may be sent to Assurity by fax, email or mail; **and** 4. To expedite your claim, you may submit additional medical evidence that supports your claim for a positively diagnosed critical illness or needed procedure. This information may include such items as pathology reports, physicians' notes, medical records and itemized bills. Any additional medical information may be submitted electronically in the policy owner's MyAssurity account when initially filing the Critical Illness Claim Questionnaire form and Confidential Information Authorization form by uploading high resolution versions of your document(s). Otherwise, the additional information may be sent to Assurity by fax, email or mail.

Additional Rider Benefits

The riders listed below are available for some Assurity Critical Illness products, but are not necessarily a part of your contract. Please review your contract to verify any riders you may have selected.

Potential Benefit	Information Needed/Required Proof for Claim
Spouse Critical Illness Rider	If your spouse wishes to file a claim for the spouse's critical illness benefits, the claim forms listed above should be completed by your spouse. Your spouse must also sign the Authorization form.
Dependent Child Critical Illness Rider	If you wish to file a claim for a child's critical illness benefits, the claim forms listed above should be completed by the parent.

If your contract includes benefits not described in this document or you have questions, please contact Assurity's Claims Department.

800-869-0355 Ext. 4484
claimsinfo@assurity.com

Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 800-869-0368

Critical Illness Claim Form
CLAIMANT STATEMENT

CLAIMANT INFORMATION

Name *First* *Middle* *Last*		Policy no.
Address *Street address* *City* *State* *Zip code +4*		
Phone no. ( )	Social Security no.	Date of birth / / *MM/DD/YYYY*

Disclaimer: Some of the conditions and services listed may not be covered by your policy.

DETAILS OF CRITICAL ILLNESS

Please check the condition for which you are filing a claim and submit the appropriate medical documentation. Incomplete information may cause a delay.

- ☐ **Invasive Cancer, Non-Invasive Cancer, Skin Cancer:** Please provide a copy of the pathology report from which the cancer was diagnosed.
- ☐ **Heart Attack:** Please submit a copy of the discharge summary, cardiology report, cardiac catheterization report, Echocardiogram report, and Emergency Room notes and lab reports.
- ☐ **Angioplasty:** Please submit a copy of the procedure report, cardiology consultation records and the discharge summary.
- ☐ **Coronary Artery Bypass Surgery:** Please submit a copy of the operative report for the surgery.
- ☐ **Sudden Cardiac Arrest:** Please submit a copy of the discharge summary, cardiology consults report, procedure report, Emergency Room records and Emergency first responder records.
- ☐ **Stroke:** Please submit a copy of the discharge summary, MRI and/or CAT images and test reports from the initial diagnosis, as well as proof of neurological deficit.
- ☐ **Transient Ischemic Attack (TIA):** Please submit medical documentation from the health care provider indicating the diagnosis, limitations, and treatment.
- ☐ **Kidney (renal) Failure:** Please provide proof of the start date for dialysis and Nephrology records.
- ☐ **Major Organ Transplant, Bone Marrow Transplant:** Please provide a copy of the operative report for the transplant and transplant clinical records.
- ☐ **Advanced Alzheimer's Disease:** Please submit medical documentation from a board certified Psychiatrist or Neurologist indicating the diagnosis and limitations they have identified. CT, MRI and PET scan of the brain should be included.
- ☐ **Advanced Parkinson's Disease, Advanced Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), Benign Brain Tumor:** Please submit copies of the Neurology records indicating the diagnosis and specific limitations.
- ☐ **Coma, paralysis:** Please submit a copy of the Neurology report indicating the diagnosis and specific limitations.
- ☐ **Loss of Independent Living:** Please submit medical documentation from the health care provider indicating the diagnosis and severity of the condition as well as documentation of the permanent inability to perform two or more Activities of Daily Living.
- ☐ **Loss of Sight, Speech, Hearing:** Please submit medical documentation from the health care provider indicating the diagnosis and specific limitations.
- ☐ **Occupational HIV:** Please submit medical documentation from the health care provider indicating the diagnosis as well as the certified laboratory results positively confirming antibody test for HIV.
- ☐ **Schizophrenia:** Please submit medical documentation from a Physician board certified in Psychiatry or Ph.D level psychologist indicating the diagnosis, limitations, and treatment.
- ☐ **Severe Burns:** Please submit medical documentation from the health care provider indicating the diagnosis and severity of burns, including percentage of burns on the body.
- ☐ **Other:** Please describe your illness. _____

FRAUD NOTICES

Unless specific state language is provided below for your state of residence, the following general fraud notice applies.

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.

AL RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, DC, LA, MA, RI RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

AZ RESIDENTS: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties

Continue to Page 2 of this form.

FRAUD NOTICES - *Continued*

CA RESIDENTS: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO RESIDENTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FL RESIDENTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

IL RESIDENTS: 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 fraud or intentional misstatements of material fact 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.

KS RESIDENTS: 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 be a crime as determined by a court of law and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

KY RESIDENTS: Any person who knowingly and with intent to defraud any insurance company or other person, files a 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.

MD RESIDENTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly or willfully presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

ME, TN, WA RESIDENTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MN RESIDENTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NC RESIDENTS: 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 may also be subject to a substantial civil penalty where and to the extent allowed by state law.

NH RESIDENTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ RESIDENTS: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NM RESIDENTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to civil fines and criminal penalties.

NY RESIDENTS: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH RESIDENTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OK RESIDENTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR RESIDENTS: Any person who knowingly and with intent to defraud an insurance company or any other person presents a false claim for payment of a loss or benefit may be guilty of insurance fraud and subject to civil fines and criminal penalties. If such misinformation is material to the content of the contract, relied upon by the insurer and either material to the risk assumed by the insurer or provided fraudulently, such action may also lead to denial of insurance benefits.

PA RESIDENTS: 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 subjects such person to criminal and civil penalties.

VA RESIDENTS: Any person who, with the intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

VT RESIDENTS: 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.

SIGNATURE

I hereby acknowledge that I have read the applicable fraud notice above.

I hereby certify the statements above are complete and accurate to the best of my knowledge.

Date (MM/DD/YYYY)	*Signature of claimant, legal representative or parent of child under 18*	*Printed name of person completing this form*

Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
800-869-0355, Ext. 4484 | FAX 800-869-0368

Critical Illness Claim Form
ATTENDING PHYSICIAN'S STATEMENT

This form should be completed by all physicians who were treating the claimant. The patient is responsible for the completion of this form without expense to Assurity Life. Please print or type. If necessary add a separate sheet. Direct any questions to our claims department at the phone numbers shown above.

GENERAL INFORMATION

(First , Middle, Last) Date of Birth *(MM/DD/YYYY)*

Patient's Name _____ ___/___/___

Diagnosis _____

When did symptoms first appear? _____

Has the patient ever received medical advice or treatment for the same or a similar condition? ☐ Yes ☐ No

CONDITION

Invasive Cancer / Non-Invasive Cancer / Skin Cancer

Date the tissue specimen, culture, blood samples or titer(s) were taken on which diagnosis of cancer is based..... ___/___/___

Was the cancer diagnosed pathologically or clinically? _____ Cancer stage _____

If the cancer was pathologically diagnosed, attach a copy of the pathology report. If the cancer was clinically diagnosed, please provide the reason that pathological diagnosis was not obtained and attach medical evidence that supports the diagnosis of cancer.

Heart Attack (Myocardial Infarction)

Does the patient's condition meet the following criteria?

Did the patient have clinical symptoms indicating a heart attack? ☐ Yes ☐ No

Did specific cardiac markers rise and fall to levels diagnostic of acute myocardial infarction? ☐ Yes ☐ No

Did the patient have new electrocardiographic changes consistent with myocardial infarction? ☐ Yes ☐ No

Did the patient have the death of a portion of the heart muscle due to inadequate blood supply? ☐ Yes ☐ No

Date the patient met all the above criteria..... ___/___/___

Angioplasty

Did the patient have a percutaneous transluminal angioplasty procedure deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries? ☐ Yes ☐ No

What was the condition that caused the need for the angioplasty? _____

Date the angioplasty occurred..... ___/___/___

Coronary Artery Bypass Surgery

Did the patient have a surgical procedure using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease to correct a narrowing or blockage of one or more coronary arteries? ☐ Yes ☐ No

What was the condition that caused the need for coronary artery bypass surgery? _____

Date the coronary artery surgery occurred..... ___/___/___

Sudden Cardiac Arrest

Did the patient have sudden unexpected loss of heart function in which the heart abruptly stopped working as the result of an internal electrical system heart malfunction due to coronary artery disease, cardiomyopathy or hypertension? ☐ Yes ☐ No

Date the pumping action of the heart failed..... ___/___/___

Stroke

Did the patient have an acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological defect? ☐ Yes ☐ No

How long did the neurological impairment last? _____

Date the stroke occurred based on documented neurological deficits and neuroimaging studies..... ___/___/___

Continue to page 2 of this form.

CONDITION - *Continued*

Transient Ischemic Attack (TIA)

Did the patient have a transient ischemic attack producing neurological impairment resulting in measurable objective neurological defect? ☐ Yes ☐ No

What clinical symptoms were present at the time of evaluation? _____

Date the transient ischemic attack occurred…… ___/___/___ How long did the neurological impairment last? _____

Kidney (Renal) Failure

Does the patient have chronic and irreversible failure of both kidneys? ☐ Yes ☐ No

Does the patient's kidney failure require periodic and ongoing peritoneal dialysis or hemodialysis? ☐ Yes ☐ No

Date the patient was first treated for signs or symptoms of this condition …… ___/___/___

Date the dialysis first began due to the irreversible failure of both kidneys to perform their essential functions…… ___/___/___

Major Organ Transplant

Did the patient undergo surgery to receive a human liver, kidney, lung, entire heart, or pancreas? ☐ Yes ☐ No

Date the patient registered under the United Network for Organ Sharing (UNOS)…… ___/___/___

Date the patient was first treated for signs or symptoms of this condition …… ___/___/___

Date the surgery occurred for the covered organ transplant…… ___/___/___

Advanced Alzheimer's Disease

Does the patient have loss of intellectual capacity involving impairment of memory and judgment as measured by cognitive and neuroradiological tests including CT scan, MRI, or PET scan of the brain? ☐ Yes ☐ No

Does the patient have significant reduction in mental and social functioning that requires substantial assistance in performing at least three of the six activities of daily living? ☐ Yes ☐ No

(Check all that apply)

☐ Bathing ☐ Continence ☐ Dressing ☐ Eating ☐ Toileting ☐ Transfer and Mobility

Date the patient met all the above criteria…… ___/___/___

Loss of Independent Living

Does the patient have the permanent inability to perform two or more activities of daily living? ☐ Yes ☐ No

(Check all that apply)

☐ Bathing ☐ Continence ☐ Dressing ☐ Eating ☐ Toileting ☐ Transfer and Mobility

What is the condition causing the need for assistance with activities of daily living? _____

Date the patient's inability to perform two or more activities of daily living became permanent…… ___/___/___

Additional Critical Illness Conditions

For what condition are you treating the patient? _____

Date you diagnosed the patient's condition…… ___/___/___

Please provide copies of any testing completed in making your diagnosis.

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VT RESIDENTS: 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.

ATTENDING PHYSICIAN'S SIGNATURE – *Attending physician, please print*

I hereby acknowledge that I have read the applicable fraud notice above.
I hereby certify the statements above are complete and accurate to the best of my knowledge.

Physician's name	Degree/Specialty			
	Street Address	*City*	*State*	*Zip+4*
Phone no. ( )	Address			

Physician's Signature (no stamp)	*Date (MM/DD/YYYY)*	*TIN or Social Security No.*

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

Confidential Information Authorization

_____ / / _____
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 LLC, 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 LLC 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 LLC.

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 LLC, 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.

_____ _____
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
402-476-6500 | 800-869-0355 | FAX 888-255-2060
Assurity® Life Insurance Company of New York
844-401-7585 | FAX 888-255-2060
Admin. Office: P.O. Box 82533, Lincoln, NE 68501-2533

Authorization Agreement for DIRECT DEPOSITS

DIRECT DEPOSIT AUTHORIZATION – must be deposited to Policyowner's bank account

Insured's Name *First, Middle, Last* | Policy No(s).

Policyowner's Name *(if other than Insured)* *First, Middle, Last*

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

Type of Account: ☐ Checking ☐ Savings

I (we) hereby authorize Assurity to initiate credit entries to my *(our)* account indicated below, and I *(we)* authorize the bank indicated below to accept and to credit the amount of such entries to my *(our)* account. Such authorization does not allow Assurity to debit entries to my *(our)* account.

Bank Name

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

Nine-digit Bank Routing No. | Your Account No.

This authority is to remain in effect until Assurity has received written notice of its termination from the Policyowner in such timely manner as to afford Assurity a reasonable opportunity to act on it. I *(we)* understand that in no event shall it be effective with respect to entries processed by Assurity prior to receipt of notice of termination.

I *(we)* hereby agree that all entries initiated under this authorization are to be governed in all respects by the Rules of the National Automated Clearing House Association and agree to be bound accordingly. Assurity may obtain a consumer report pursuant to the federal Fair Credit Reporting Act (FCRA) for purposes of verifying and authenticating this account. I *(we)* hereby consent and authorize Assurity to obtain such a report and I *(we)* understand that if any adverse action is taken based on the report, I *(we)* will be notified according to the FCRA.

_____ _____
Signature of Policyowner/Account Holder *Date (MM/DD/YYYY)*

_____ ( ) _____
Printed Name of Policyowner Account Holder *Telephone No.*