

Simplified Critical Illness Insurance

UNDERWRITING GUIDE

FOR AGENT USE ONLY. Not for use with consumers.
Product availability, features and rates may vary by state.

16-088-02291 (4/14)

Important Notice

Underwriting Guide for Simplified Critical Illness Insurance

This policy is underwritten by Assurity Life Insurance Company, Lincoln, Nebraska, and may contain reductions of benefits, limitations and exclusions. For costs and complete details of the coverage, please contact Assurity Life Insurance Company or review the policy. **The specific policy is your ultimate authority for any questions about this product.**

This is a generic underwriting guide. **Product availability, features and rates may vary by state.** Your state may require a state-specific contract and/or application. State-specific applications are available on AssureLINK at <https://assurelink.assurity.com> in the Product Center for each product by selecting the Applications/Forms option on the left.

This is an underwriting guide for policy Form No. I H0810 and CI 005. Any prior guide does not apply to this product.

This underwriting guide is for agent use only. It is not for use with consumers.

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Field Underwriting Guidelines

Good field underwriting can create a win/win situation. Asking your client a few questions before the application process can save time and frustration for everyone involved. If information provided indicates your client will not qualify for Simplified Critical Illness insurance, you can immediately shift gears to another product.

Simplified Critical Illness utilizes a simplified underwriting approach – the application is an accept/reject short form that often gives some indication of eligibility. Utilizing sample applications below as a guide, if the applicant can truthfully answer “no” to some health and family history questions, and falls within the height and weight limits (*see Height/Weight Build Table*), they will generally be eligible for coverage.

Applications vary by state, generally with two different forms – form nos. 75-340-02241 and APP-04-CI. A sample of health sections for these two applications, suggested for pre-screening, are shown below

Pre-Screening Health Questions – Application Form No. 75-340-02241

The applicant must answer “no” to questions 1 through 5. The application below is for Nebraska. State-specific applications are available on AssureLINK at <https://assurelink.assurity.com> in the Product Center for each product by selecting the Applications/Forms option on the left.

5. HEALTH SECTION	
1. During the past 5 years , has any Proposed Insured received medical treatment from a member of the medical profession for, or experienced symptoms of, any of the following? If YES, indicate all that apply. ☐ Yes ☐ No ☐ Disorder of the heart or circulatory system ☐ Unexplained weight loss ☐ Abnormal Pap smear ☐ Unexplained fatigue ☐ Unexplained dizziness ☐ Fibrocystic breast disease, recurrent breast tumors, or unexplained tumors/growths	
2. Has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of, any of the following? If YES, indicate all that apply. ☐ Yes ☐ No ☐ Stroke or TIA (<i>transient ischemic attack</i>) ☐ Heart attack ☐ Alcoholism ☐ Drug abuse ☐ Cancer (<i>other than skin cancer</i>) ☐ Melanoma ☐ Skin cancer (<i>2 or more occurrences</i>) ☐ Diabetes ☐ Hepatitis B or C ☐ Cirrhosis ☐ Abnormal kidney functions ☐ Systolic blood pressure 150 or greater (<i>within the past 6 months</i>) ☐ Diastolic blood pressure 95 or greater (<i>within the past 6 months</i>) ☐ Ulcerative colitis or Crohn's disease ☐ Mental or nervous disorder ☐ Disease or disorder of the nervous system ☐ Alzheimer's disease or senile dementia ☐ Chronic lung disease (<i>COPD</i>) or emphysema ☐ Recurrent human papillomavirus (<i>HPV</i>) or sexually transmitted disease (<i>within the past 5 years</i>) ☐ Acquired immune deficiency syndrome (<i>AIDS</i>), <i>AIDS-related complex (ARC)</i>, human immunodeficiency virus infection (<i>HIV, symptomatic or asymptomatic</i>) or any <i>AIDS-related condition</i>	
3. During the past 2 years , has any Proposed Insured been advised by a member of the medical profession: a. Of any abnormal diagnostic test results or been advised to have any diagnostic tests (<i>including self-administered</i>) which has not been completed, or for which the results have not been received? ☐ Yes ☐ No b. To undergo any treatment, surgery, hospitalization or consultation with a medical professional which has not been completed? ... ☐ Yes ☐ No c. To refer to a specialist and have not yet done so? ☐ Yes ☐ No If YES, what specialty: _____	
4. During the past 5 years , has any Proposed Insured needed assistance or personal supervision to perform any activities of daily living (<i>toileting, transferring, continence, eating, bathing, dressing, grooming, walking or managing medications</i>)? ☐ Yes ☐ No	

5. HEALTH SECTION (continued)

5. Have **2 or more** of any Proposed Insured's natural parents, brothers or sisters, either living or deceased, been diagnosed with the same conditions from the following list?

- a. Heart disease, stroke, diabetes, kidney disease or breast cancer prior to age 60? ☐ Yes ☐ No
- b. Colorectal cancer or Alzheimer's disease or senile dementia prior to age 75? ☐ Yes ☐ No
- c. Any other same type of cancer in both relatives prior to age 55? ☐ Yes ☐ No

If YES, please list conditions and relationship to the Proposed Insured(s): _____

Pre-Screening Health Questions – Application Form No. APP-04-CI

The applicant must answer "no" to questions B1 through B4 and C1 through C6. The application below is for Kansas. State-specific applications are available on AssureLINK at <https://assurelink.assurity.com> in the Product Center for each product by selecting the Applications/Forms option on the left.

B. Answer the Following Questions:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Does the Proposed Insured(s) have any other Critical Illness (lump sum diagnostic benefits) coverage in force and applied for? If Yes , list company name and amount. | ☐ | ☐ |
| <div style="border: 1px solid black; height: 15px; width: 100%;"></div> | | |
| 2. If under age 65, is the Proposed Insured(s) receiving Medicare? | ☐ | ☐ |
| If Yes , name of person(s) _____ | | |
| 3. In the past 5 years, has the Proposed Insured(s) been postponed or declined Critical Illness coverage? | ☐ | ☐ |
| If Yes , name of person(s) _____ | | |
| 4. Has there been, or will there be, a lapse, surrender, loan, or other change to any existing health insurance as a result of, or in anticipation of, this application? | ☐ | ☐ |
| 5. Estimated Annual Income \$ _____ Sources: _____ | | |

C. Health History (Questions 1 through 6 apply to all Proposed Insured(s)):

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. During the past two years, has the Proposed Insured(s) received medical care from a member of the medical profession for, or experienced symptoms of, any of the following? If Yes, indicate all that apply. | ☐ | ☐ |
| ☐ Disorder of the heart or circulatory system ☐ Unexplained Fatigue
☐ Unexplained Weight Loss ☐ Unexplained Dizziness
☐ Fibrocystic breast disease, recurrent breast tumors, or unexplained tumors/growths ☐ Abnormal Pap Smear | | |
| 2. Has the Proposed Insured(s) ever received medical care from a member of the medical profession for, or been diagnosed with, any of the following? If Yes, indicate all that apply. | ☐ | ☐ |
| ☐ Stroke (including Transient Ischemic Attack) ☐ Diabetes
☐ Heart Attack ☐ Hepatitis B or C
☐ Alcoholism ☐ Chronic Lung Disease
☐ Drug Abuse ☐ Cirrhosis
☐ Cancer (other than skin cancer) ☐ Skin Cancer (2 or more occurrences)
☐ Melanoma ☐ Ulcerative Colitis
☐ Abnormal Kidney Functions ☐ Crohn's Disease
☐ Recurrent Human Papilloma virus (HPV) or Sexually Transmitted Disease (within the past 5 years) ☐ Alzheimer's or Senile Dementia
☐ Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus infection (symptomatic or asymptomatic) or any AIDS related condition ☐ Systolic Blood Pressure 150 or greater within the last 6 months
☐ Diastolic Blood Pressure 95 or greater within the last 6 months | | |

3. Does the Proposed Insured(s) intend to live or travel outside the United States or Canada for more than two months during the next 24 months? ☐ ☐
4. During the past two years has the Proposed Insured(s) been advised by a member of the medical profession:
 a) of any abnormal diagnostic test results or been advised to have any diagnostic tests (includes self-administered) which have not yet been completed? ☐ ☐
 b) to undergo any treatment, hospitalization or surgery which has not yet been completed? ☐ ☐
5. During the past five years, has the Proposed Insured been unable to perform any of the following activities on his/her own: transferring in or out of a chair or bed, dressing, bathing, feeding, toileting or continence? ☐ ☐
6. Have any **two or more** of the Proposed Insured's natural parents, brothers or sisters, either living or deceased, been diagnosed with the **same condition(s)** from the following list:
 • Heart disease, stroke, diabetes, kidney disease or breast cancer prior to age 60? ☐ ☐
 • Colorectal cancer or Alzheimer's or Senile Dementia prior to age 75? ☐ ☐
 • Any other same cancer in both relatives prior to age 55? ☐ ☐
- If any question in this section (Section C, Questions 1 – 5) is answered "Yes", list the name(s) of the person(s).

7. Has the Proposed Insured(s) used any tobacco or nicotine product during the past 12 months? ☐ ☐
 If "Yes", list name(s): _____

General Underwriting Guidelines

Non-U.S. Citizens

Applications may be taken for U.S. citizens who permanently reside in the U.S. or for permanent resident aliens who have lived in the U.S. for at least one year and do not plan to return to their native country on a permanent basis. The applicant's resident alien card number must be submitted with the application for a permanent resident alien. A photocopy of the resident alien card can be included in case it is required.

Personal History Interviews and Attending Physician's Statement

An MIB (Medical Inspection Bureau) report will be requested by the underwriting department for all applications. For any MIB results related to application questions, a personal history interview and APS (attending physician's statement) will also be ordered. Please inform every applicant that he/she may receive a phone call regarding an interview.

Replacement Guidelines

If existing critical illness insurance is to be replaced, the following states require that a replacement form be completed and submitted with the application, and that a completed copy be left with the applicant:

Arkansas	Illinois	New Jersey	Utah
Colorado	Iowa	Oklahoma	Vermont
Connecticut	Kentucky	Pennsylvania	Virginia
Delaware	Maine	Rhode Island	Washington
Florida	Massachusetts	South Carolina	West Virginia
Idaho	New Hampshire	Texas	Wisconsin

Backdating Policy Issue Date

Assurity will backdate the policy issue date 30 days prior to application's signature date to "save age" (i.e. allow for a lesser age to qualify for a lesser rate). However, Assurity will not backdate the policy issue date to "save eligibility" (i.e. allow for a lesser age to meet eligibility requirements).

Financial Underwriting Guidelines

Bankruptcy

Consideration of financial stability is an important part of the underwriting process. No coverage will be considered if bankruptcy is ongoing or pending, and until bankruptcy is discharged.

Medical Underwriting Guidelines

Height/Weight Build Chart

The proposed insured must be within the minimum and maximum weight for their height to be eligible for coverage.

HEIGHT/WEIGHT BUILD CHART						
Height	Minimum Weight	Maximum Weight		Height	Minimum Weight	Maximum Weight
4' 8"	74	168		5' 8"	110	245
4' 9"	77	174		5' 9"	113	252
4' 10"	80	180		5' 10"	117	260
4' 11"	83	186		5' 11"	121	268
5' 0"	86	192		6' 0"	125	276
5' 1"	89	198		6' 1"	129	284
5' 2"	92	204		6' 2"	133	292
5' 3"	95	210		6' 3"	137	300
5' 4"	98	217		6' 4"	142	308
5' 5"	101	224		6' 5"	147	316
5' 6"	104	231		6' 6"	152	324
5' 7"	107	238				

Additional Underwriting Information to Expedite Processing

Underwriting action often depends on answers to a number of basic questions specific to the condition or situation. In addition to information provided in the application, the underwriting process can be expedited by providing such additional underwriting information as outlined below. On a separate sheet of paper attached to the application, provide the information as specified for conditions or situations listed under conditions 1 through 13 in the following section. For any condition or situations not listed, please provide information according to No. 14.

1. Arthritis

- Applicant's name
- Type of arthritis
- Joints and areas involved
- Currently prescribed medications and treatment
- Name, address and phone number of all physicians and medical facilities

2. Asthma, emphysema or bronchitis

- Applicant's name
- Number of attacks in the past 12 months
- Date of last attack
- Hospitalizations due to respiratory condition
- Date of last hospitalization (if any)
- Currently prescribed medications and treatment
- Name, address and phone number of all physicians and medical facilities

3. Back or neck pain or problems

- Applicant's name
- Diagnosis (sprain, strain, herniated disc, etc.)
- Area of the back or neck affected
- Date of last symptom
- Currently prescribed medications and treatment
- Date of last treatment
- Name, address and phone number of physician and medical facilities

4. Diabetes or glucose metabolism abnormalities

- Applicant's name
- Diagnosis
- Date of onset or diagnosis
- Currently prescribed medications and treatment
- Date(s) of any hospitalizations
- Related conditions – eye disorders, kidney disorders, heart disorders, recurrent infections, circulatory problems, amputations, skin ulcers
- Other conditions/symptoms due to diabetes
- Name, address and phone number of physician and medical facilities

5. Epilepsy or seizure

- Applicant's name
- Type of epilepsy or seizure
- Date of onset or diagnosis
- Date of last seizure
- Currently prescribed medications or treatment
- Name, address and phone number of all physicians and medical facilities

6. Heart attack, angina or coronary artery disease

- Date of onset or diagnosis
- Diagnosis
- Date of last symptoms
- Tests completed or prescribed
- Currently prescribed medications and treatment
- Name, address and phone numbers of all physicians and medical facilities

7. Heart murmur

- Applicant's name
- Date of onset or diagnosis
- Type of murmur
- Restrictions to activities
- Currently prescribed medications and treatments
- Name, address and phone number of physician and medical facilities

8. High blood pressure

- Applicant's name
- Date of onset or diagnosis
- Currently prescribed medications or treatment
- Name, address and phone number of physicians and medical facilities

9. Kidney or urinary tract disease or disorder

- Applicant's name
- Disease or disorder
- Currently prescribed medications and treatments
- Tests completed
- Name, address and phone number of physician and medical facilities

10. Stomach and/or digestive tract disorders

- Applicant's name
- Diagnosis
- Date of onset
- Date of last symptoms
- Currently prescribed medications and treatment
- Name, address and phone number of physicians and medical facilities

11. Tumor, polyp or cyst

- Applicant's name
- Diagnosis
- Location of growth
- Date of removal
- Currently prescribed medications and treatment
- Follow-ups planned
- Name, address and phone number of physician and medical facilities

12. Driving under the Influence (DUI)

- Applicant's name
- Date of offense
- Number of DUI offenses
- License currently suspended
- Current employment

13. Drug or alcohol abuse

- Applicant's name
- Types of drugs or alcohol used
- Dates of last drug or alcohol use
- Treatment dates
- Current affiliation in support group - Alcoholics Anonymous (AA), Narcotics Anonymous (NA)

14. All other medical conditions

- Applicant's name
- Diagnosis
- Date of onset or diagnosis
- Residual or ongoing symptoms
- Date of last symptoms
- Tests completed or prescribed
- Currently prescribed medications or treatment
- Names, addresses and phone numbers of all physicians and medical facilities

About Assurity

Assurity Life Insurance Company's origins are rooted in a 120-year legacy of providing long-term security to policyholders that has earned generations of customers' confidence and trust.

Assurity Life serves customers across the nation, offering disability income, critical illness, accident and life insurance, annuities and specialty insurance plans through our representatives and worksite distribution.

With assets exceeding \$2 billion, Assurity Life has built a reputation for "best in class" service and sound, conservative business practices with a disciplined approach to financial management. Headquartered in

Lincoln, Neb., Assurity Life has earned a high rating from A.M. Best Company, one of the insurance industry's leading independent analysts. For more information about this rating, please visit www.ambest.com or www.assurity.com.

We're proud of our history of integrity, financial accountability...and helping people through difficult times.

Revisions to this Underwriting Guide

Date	Section	Update
04/28/14	General Underwriting Guidelines	Changed "telephone inspection report" to "personal history interview"
02/11/14	-	Revised format of all content
02/11/14	-	Moved underwriting information to this separate underwriting guide