

**Assurity® Life Insurance Company**  
1526 K Street • PO Box 82533  
Lincoln, NE 68501-2533  
Toll Free 800-276-7619

### **Long Term Care Insurance License Appointment Checklist**

The procedure for licensing agents differs in each state. All states, however, are uniform in requiring that an agent be properly licensed **before** soliciting insurance sales. Assurity supports this position and requests your complete compliance with the licensing laws of your state(s). Please review the Appointment Guidelines for Business Received (reverse side) for more information.

You **must** return all of the following items completed in full to Contracting at Assurity. Information should be typed or printed legibly. Missing items will delay the contracting and appointment process.

- Appointment Application**  
When appointing an agency, you must include **both** the tax identification number and social security number on the Appointment Application.  
\*\* The e-mail address and other information provided is confidential and will be used for Assurity business purposes only. E-mail addresses are requested to facilitate communication between you and the company and/or its affiliates. E-mail addresses are not sold or furnished to any other entity except as may be required by law or regulatory authority.
- Agreement**  
Sign, date and return the Agreement and Commission Schedule.
- Supplement to Agent Agreement for Sales of Products Subject to HIPAA**  
Sign, date and return the Supplement.
- Authorization for the Release of Information**
- Authorization Agreement for Automatic Deposits**
- W-9 Form**  
All potential agents must complete and submit a W-9 form. If we are paying commissions to your agency, the W-9 must be completed with agency information and tax identification number.
- Copies of Licenses**  
Current copies of your resident and non-resident licenses for all states where you or your agency need to be appointed must be attached. If commissions are to be paid to your agency, send a current copy of the agency license along with the copy of your license.
- Copies of Long Term Care Insurance Continuing Education Certificate (If required by state)**  
Colorado, California, Illinois, Indiana, Maryland, and Washington require agents to complete LTCI continuing education **prior** to the sale of Long Term Care Insurance.
- Non-Resident Appointment Fees**  
Refer to the Non-Resident Appointment Information form for fee information. Fees for all states where you need a non-resident appointment must be included. Make your check payable to **Assurity Life Insurance Company**.
- Credit Card Authorization**  
If you would like to charge your appointment fees to your credit card, complete and sign the Credit Card Authorization form and send in with other forms.

**ATTENTION MASSACHUSETTS AGENTS: You must complete Assurity's Massachusetts Long Term Care Insurance Product Training prior to be contracted with Assurity Life Insurance Company. Please submit your request for this information to [ltccontracting@assurity.com](mailto:ltccontracting@assurity.com).**

**NOTE: In doing business with Assurity, you will need to access our extranet site to obtain your commission statements and production reports as Assurity does not mail any commissions or production reports. You will receive more information about this once you have become contracted and appointed with Assurity.**



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**Assurity Life Insurance Company  
Long Term Care Insurance Contracting Transmittal**

**\*\*This form must be completed when submitting paperwork to Assurity\*\***

Date: \_\_\_\_\_

New Agent/Agency Name: \_\_\_\_\_

Contract Level: \_\_\_\_\_

Recruiting Agent: \_\_\_\_\_ Agent #: \_\_\_\_\_

**Subordinate Contracts Included:**

New Agent/Agency Name

SSN/Tax ID

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



## Long Term Care Insurance Appointment Application

**COMPLETION INSTRUCTIONS**

**Individual Applicants:** Complete sections I, III, IV, V & VI. Must sign and return applicable contracts.

**Corporations:** Complete sections I, II, III, IV, V & VI. All Corporate appointments require that appointment information be submitted on at least one officer concurrent with the Corporation. Must sign and return applicable contracts for agency and Solicitor contracts for officer.

**Solicitor Applicants:** Complete sections I, II, III, IV, V & VI. Must sign and return Solicitor contracts.

**PLEASE PRINT OR TYPE AND RESPOND TO ALL QUESTIONS. DO NOT USE ABBREVIATIONS.**

**I. GENERAL INFORMATION**

Mr.  Mrs.  Ms.  Miss Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Maiden or other name (If applicable) \_\_\_\_\_

Residence Address \_\_\_\_\_ Residence Phone ( \_\_\_\_\_ ) \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Business Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Business Address \_\_\_\_\_ Fax Number ( \_\_\_\_\_ ) \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address\*\* \_\_\_\_\_ Gender (Optional)  M  F

\*\* The e-mail address and other information provided is confidential and will be used for Assurity business purposes only. E-mail addresses are requested to facilitate communication between you and the company and/or its affiliates. E-mail addresses are not sold or furnished to any other entity except as may be required by law or regulatory authority.

Primary mailing address to receive Company Information including Underwriting and Compensation correspondence  
 Business Address  Residence Address

**II. AGENCY INFORMATION**

Agency Name \_\_\_\_\_

Corporation  Partnership Tax I.D. # \_\_\_\_\_

List officers and their titles below:

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

**III. ASSIGNMENT OF COMMISSIONS (Select one option)**

Paid Direct: The commission check is made payable and sent to the agent.

Agency Direct/Solicitor: The commission check is made payable and sent to the Agency listed in Section II.

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**IV. LICENSES**

You must include current license copies for each state in which you are requesting an appointment. If you are requesting non-resident appointments, you must include the proper appointment fee(s).

Current Resident License # \_\_\_\_\_ State(s) for Appointment \_\_\_\_\_

\*\*If requesting non-resident Florida appointment, list all counties where appointment is required \_\_\_\_\_



**V. LONG TERM CARE INSURANCE CONTINUING EDUCATION**

**Attention Massachusetts Agents: You must complete Assurity's Massachusetts Long Term Care Insurance Product Training prior to contracting with Assurity Life Insurance Company. Please submit your request for this information to ltcontracting@assurity.com.**

Colorado, California, Illinois, Indiana, Maryland, and Washington require agents to complete LTCI continuing education prior to the sale of Long Term Care Insurance.

Have you completed LTCI continuing education?  Yes  No (Please include a copy of your LTCI continuing education certificate)

**VI. ERRORS AND OMISSIONS COVERAGE**

All Assurity producers must maintain a minimum coverage of \$500,000 for each claim per agent with a maximum \$10,000 deductible.

Do you have Errors and Omissions Coverage?  Yes  No

Please provide the carrier for your Errors and Omissions coverage, the policy number and the name of the insured. \_\_\_\_\_

**VII. QUALIFICATION QUESTIONS**

- 1) Have you lived in a different state or county than your present one within the last 5 years?  Yes  No  
If Yes, please list state/county \_\_\_\_\_
- 2) Have you ever been convicted for any offense or pleaded guilty to any misdemeanor or felony charges or have charges currently pending against you or a business with which you are connected?  Yes  No
- 3) Do you currently have a pending bankruptcy or have you ever filed for bankruptcy, been declared bankrupt or insolvent, had your salary garnished?  Yes  No
- 4) Are you at the present involved in any litigation or are there any unsatisfied judgments or liens (including state or federal tax liens) against you?  Yes  No
- 5) Have you ever had a bond denied, paid out or revoked?  Yes  No
- 6) Has any insurance company canceled any contract with you or appointment of you as a sales person for any reason other than non-production of business or at your own request?  Yes  No
- 7) Are you indebted to any Insurance Company/Agency/Manager (including debit balance)?  Yes  No
- 8) Have you ever had any complaints against your conduct that resulted in a return of premium to any insured?  Yes  No
- 9) Have you ever been fined, suspended, placed on probation, reprimanded, entered into a consent order by any insurance department, the SEC, or any other regulatory authority?  Yes  No
- 10) Have you ever had an insurance and/or securities license refused/suspended/revoked or currently restricted or under investigation by any insurance department, the SEC, or any other regulatory authority?  Yes  No
- 11) How many years have you been licensed as an insurance agent? \_\_\_\_\_
- 12) How many companies are you currently contracted with? \_\_\_\_\_

**\*You must attach details and dates for any questions answered Yes above.**

I hereby certify that the statements contained in this Appointment Application are true and correct to the best of my knowledge and belief. I understand that any false statements on this Application may be considered as sufficient cause for rejection of this Application, or for termination if such false statement is discovered subsequently.

I understand and agree that:

- I can solicit business only in states where I am licensed and appointed with Assurity Life Insurance Company.
- I will not solicit business in states that prohibit solicitation prior to my appointment.
- As a general rule, it is not acceptable to make a solicitation anywhere other than the resident state of the applicant.
- I will abide by all written rules and regulations (subject to change at any time) set forth by the Company.

Agent's Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>THIS BOX MUST BE COMPLETED</b>	
WHO IS YOUR RECRUITING AGENT? _____	AGENT ID _____



**ASSURITY® LIFE INSURANCE COMPANY**

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**Disclosure and Authorization for Consumer Reports**

**DISCLOSURE**

In connection with your application for contract services with Assurity Life Insurance Company, a consumer report or an investigative consumer report will be requested during the application process and if contracted, during your contract term. It may contain information about your character, general reputation, personal characteristics, mode of living, qualifications and credentials. The nature and scope of the consumer report or investigative consumer report is the procurement of reports such as consumer credit, criminal records, civil records, driving records, employment verification, education verification, professional license verification and others. I understand that, upon written request within a reasonable period of time, I am entitled to additional information concerning the nature and scope of this investigation. I understand that pursuant to the Fair Credit Reporting Act (FCRA), I have the right to know if adverse action is being considered against me as a result of information contained in this report, that I have the right to a copy of this report prior to any adverse action taken against me and to dispute the accuracy of any information in this report by contacting the consumer reporting agency. I understand that I may have additional rights under state law which I may determine by contacting my state or local consumer protection agency.

<b>Consumer Reporting Agency:</b>	<b>Business Information Group PO Box 130 Southampton, PA 18966 (215) 396-9870</b>
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Oklahoma, Minnesota, and California applicants may obtain a copy of this consumer report by checking this box. This report will be sent to California applicants within three (3) days of the employer receiving the report.

California applicants only: For consumer reports which were not obtained by a consumer reporting agency, by checking this box you waive the right to obtain a copy of the report. If unchecked, you will receive this report within 7 days of the employer receiving it.

California only: For reports obtained by Business Information Group, California applicants also may review the file Business Information Group maintains on you during normal business hours, upon submitting proper I.D. and by paying fees associated with making copies of those files. In the State of California, a new Disclosure and Authorization/Release of Information form is required each time a subsequent Consumer Report/Investigative Consumer Report is going to be requested. The nature and scope of the consumer report or investigative consumer report is the procurement of reports such as consumer credit, criminal records, civil records, driving records, employment verification, education verification, professional license verification and others.

**AUTHORIZATION / RELEASE OF INFORMATION**

I have carefully read and understand the above Disclosure. I hereby authorize the obtaining of driving records, consumer reports and investigative consumer reports at any time after receipt of this authorization. I authorize without reservation, any party or agency contact by Assurity Life Insurance Company, to furnish information about my character, reputation, personal characteristics, credentials, and/or credit and indebtedness. I understand this may involve obtaining driving records, personal interviews with sources such as schools, employers, supervisors, friends, neighbors, associates, state, federal or local agencies, and public record or law enforcement agencies. I further authorize ongoing procurement of these reports at any time during my continued employment or contract for services, unless specifically prohibited by state law. I also agree that a fax or photocopy of this authorization with my signature shall be accepted with the same authority as the original.

I further understand and authorize by signing below, that in accordance with the legitimate business practices of Assurity Life Insurance Company that copies of my application and consumer reports may be furnished to the affiliates, assignees or agents of Assurity Life Insurance Company.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
mm/dd/yyyy

**IDENTIFICATION INFORMATION FOR CONSUMER REPORTING AGENCY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
First / MI / Last (Please Print or Type) mm/dd/yyyy



**INVESTIGATIVE CONSUMER REPORTING AGENCIES ACT**  
**California Civil Code Section 1786.22**

- (a) An Investigative Consumer Reporting Agency shall supply files and information required under Section 1786.10 during normal business hours and on reasonable notice.
- (b) Files maintained on a consumer shall be made available for the consumer's visual inspection, as follows:
  - (1) In person, if he appears in person and furnishes proper identification. A copy of his file shall also be available to the consumer for a fee not to exceed the actual costs of duplication services provided.
  - (2) By certified mail, if he makes a written request, with proper identification, for copies to be sent to a specified addressee. Investigative Consumer Reporting Agencies complying with requests for certified mailings under this section shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the investigative consumer reporting agencies
  - (3) A summary of all information contained in files on a consumer and required to be provided by Section 1786.10 shall be provided by telephone, if the consumer has made a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to the consumer.
- (c) The term "proper identification" as used in subdivision (b) shall mean that information generally deemed sufficient to identify a person. Such information includes documents such as valid driver's license, social security account number, military identification card, and credit cards. Only if the consumer is unable to reasonably identify themselves with the information described above, may an Investigative Consumer Reporting Agency require additional information concerning the consumer's employment and personal or family history in order to verify his identity
- (d) The Investigative Consumer Reporting Agency shall provide trained personnel to explain to the consumer any information furnished them pursuant to Section 1786.10.
- (e) The Investigative Consumer Reporting Agency shall provide a written explanation of any coded information contained in files maintained on a consumer. This written explanation shall be distributed whenever a file is provided to a consumer for visual inspection as required under Section 1786.22.
- (f) The consumer shall be permitted to be accompanied by one other person of their choosing, who shall furnish reasonable identification. An Investigative Consumer Reporting Agency may require the consumer to furnish a written statement granting permission to the consumer reporting agency to discuss the consumer's file in such person's presence.



## Request for Taxpayer Identification Number and Certification

**Give form to the  
requester. Do not  
send to the IRS.**

Print or type  
See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ _____	
<input type="checkbox"/> Exempt from backup withholding	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
+
or
Employer identification number
+

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

**AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS**

(1) I (we) hereby authorize the Company to initiate credit entries to my (our)  **checking**  **savings** account in the entity named below ("Depository Institution"), and I (we) authorize the Depository Institution to accept and to credit the amount of such entries to my (our) account. Such authorization does not allow the Company to debit entries to my (our) account.

(2) DEPOSITORY INSTITUTION: \_\_\_\_\_

(3) CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

(4) BANK ROUTING NO.: \_\_\_\_\_ ACCOUNT NO.: \_\_\_\_\_

This authority is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company a reasonable opportunity to act on it and in no event shall it be effective with respect to entries processed by the Company prior to receipt of notice of termination.

The undersigned hereby agree(s) that all entries initiated hereunder are to be governed in all respects by the Rules of the National Automated Clearing House Association and agree(s) to be bound thereby.

(5) AGENT'S NAME (please print): \_\_\_\_\_

(6) AGENT'S ID NO. (if known): \_\_\_\_\_

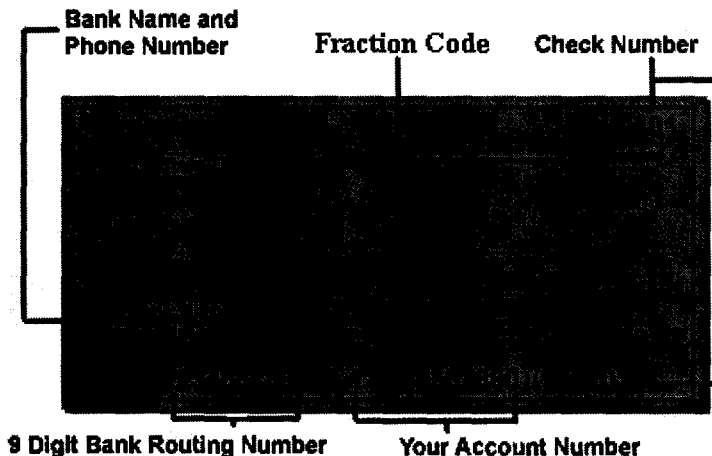
(7) DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_

**Notes for completing form:**

- (1) - Indicate if checking or savings account;
- (2) - through (5) - Complete all information;
- (6) - If new agent, leave blank; otherwise complete
- (7) - Date and sign.

Please fill out this form and mail to the address shown above, Attn: Contracting, or fax to 402-437-4640.

**Please confirm that your Routing number and Account number are correct.**



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Toll Free 800-276-7619 Fax 402-437-4640

### CREDIT CARD AUTHORIZATION

I authorize Assurity Life Insurance Company to charge the credit card listed below in the amount of \_\_\_\_\_ for the contracting appointment fees for which I am applying today.

**I ACKNOWLEDGE:**

1. USE OF THE CREDIT CARD FOR PAYMENT IS OPTIONAL;
2. THIS AUTHORIZATION DOES NOT COVER THE CHARGING OF FUTURE FEES;
3. THIS CHARGE WILL BE INITIATED ONLY WHEN THE ACCOMPANYING APPLICATION(S) IS (ARE) ACCEPTED

Name on Card \_\_\_\_\_

Card/Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Signature \_\_\_\_\_

Date of Signature \_\_\_\_\_

Mastercard

Visa

Discover

★ Please Note: Debit cards may only be used to pay for contracting appointment fees if the card shows the Mastercard or Visa logo.



**ASSURITY® LIFE INSURANCE COMPANY**  
**AGENT AGREEMENT**

Accepted:

\_\_\_\_\_  
By: Signature of Agent or Firm Principal

\_\_\_\_\_  
Print or Type Name and Title Here

**ASSURITY LIFE INSURANCE COMPANY**

This Agreement is effective \_\_\_\_\_

Approved:

\_\_\_\_\_  
Company Officer

This Agreement is between the Agent who signed this Agreement (referred to as "you," "your," and/or "Agent" in this Agreement) and Assurity Life Insurance Company (we will be referred to as "Assurity," "our," "we," "us," and "the Company"). The provisions stated in all supplements, commission rules, and schedule of commissions are incorporated into and made a part of this Agreement. This Agreement shall become effective on the date shown above.

**1. AUTHORITY**

You are appointed to represent Assurity in the state(s) in which you maintain proper license and/or appointment and the Company is duly licensed. You hereby accept such appointment and agree to comply with this Agreement as well as all operating, financial and underwriting guidelines, rules and regulations of the Company and the laws and regulations of the state(s) in which you operate. You are authorized to act as an agent on behalf of Assurity for the purpose of developing and supervising the distribution of Assurity's insurance products. Specifically, you are authorized to: 1) recruit and recommend persons for appointment by Assurity, 2) train and supervise such agents in accordance with Assurity's business rules and the requirements of the state(s) in which they are licensed and in which they act as an agent for Assurity, and 3) solicit applications for the insurance policies written by Assurity and approved for marketing.

**2. RELATIONSHIP**

You are an independent contractor and nothing in this or any other agreement between you and the Company shall be construed to create the relationship of employee or employer between you and the Company.

You are free to exercise your own judgment in determining when, how and to whom you sell Assurity policies. You choose the time, place and manner of sale, but you are to conform to state law and regulation and our rules and instructions that are not inconsistent with the independent contractor relationship.

You also acknowledge that all agents in your hierarchy are independent contractors of Assurity and, at a subagent's election or for good cause, can be transferred by Assurity according to Assurity's transfer rules.

**3. DUTIES**

You are required to follow certain guidelines while exercising the authority granted under this Agreement. These guidelines include, but are not limited to, the following:

- a. For any applications solicited by you, you shall also collect the first premium. You shall submit applications and first premiums immediately to Assurity.
- b. Service and help us keep in force the policies you sell for the Company.
- c. Segregate any monies you receive for us and hold them in trust until delivery. You shall not use such funds for any purpose.
- d. You shall notify Assurity immediately upon becoming aware of any felony convictions relating to you or any agent in your hierarchy.
- e. You shall comply with Assurity's policies and procedures concerning the replacement of life, health and annuity contracts. A replacement occurs whenever an existing policy or contract is terminated, converted, or otherwise changed in value. You shall recommend the replacement only when replacement is in the best interest of the customer. You shall fully disclose any and all relevant information to the customer regarding the financial impact to the customer of the replacement, whether a new contestability period and/or suicide clause will start under the new policy (if applicable), and whether the customer will have to resubmit to underwriting to purchase the new policy. You agree never to recommend that a customer cancel an existing policy until a new policy is in force, and the customer has determined that the new policy is acceptable.
- f. You agree to adhere to Assurity's rules concerning ethical market conduct which require you to:
  - i. carefully evaluate the insurance needs and financial objectives of your clients, and use sales tools (e.g. sales brochures and policy illustrations) to determine that the insurance or annuity you are proposing meets these needs;
  - ii. maintain a current license and valid appointment in all states in which you promote the sale of Assurity products to customers and keep current of changes in insurance laws and regulations by reviewing the bulletins and newsletters published by the state insurance departments and Assurity;
  - iii. comply with Assurity's policies concerning replacements, and refrain from providing false or misleading information about a competitor or competing product or otherwise making disparaging remarks about a competitor;
  - iv. submit, prior to use, all advertising materials intended to promote the sale of Assurity products to us for approval;
  - v. immediately report to us any customer complaints, and assist us in resolving the complaint to the satisfaction of all parties; and
  - vi. communicate these standards to any agent in your hierarchy and request their agreement to be bound by these conditions as well.

**4. LIMITATIONS OF AUTHORITY**

You do not have authority to and you shall not:

- a. Interfere with any person's business relationship with the Company.
- b. Accept risks, incur debt or liability, or make contracts in our name or on our behalf.
- c. Promise reinstatement of any policy or coverage, or commit Assurity to any action regarding any claim.
- d. Waive, alter, modify or change any Company policy, terms, rates or customary requirements.
- e. Deliver policies except in accordance with our instructions.
- f. Start legal actions in our name.



- g. Extend credit to applicants or insureds, personally pay any applicant's or insured's premiums, or allow extra time to pay a premium.
- h. Collect any premium other than the initial premium unless we authorize it.
- i. Endorse checks or any negotiable instrument payable to or intended for the Company.
- j. Deliver any policy when you or your agents have knowledge of any impairment of the applicant's health either not disclosed on the application or that occurred subsequent to the securing of the application.

#### 5. COMPENSATION

Your compensation shall be based on your personal production and the production of all agents assigned to you. You will receive payments as shown in the Commission Schedule ("Schedule"), as amended from time to time, for premiums received on policies issued by the Company for applications secured under this Agreement. Commissions will be paid according to the Commission Schedule that is in effect on the written date on the policy application. The Schedule states the required repayments of compensation for lapsed, terminated, or surrendered policies. We can change the Schedule, but any change will not affect business applied for prior to the effective date of the change. Payment of compensation will be made at such times and in any manner as we determine. You must access our web site to obtain commission statements and production reports. You must object to any transactions shown on EFT statements and compensation reports within 30 days of receiving them, or they will be deemed to be conclusive.

Your right to commissions shall be deemed fully vested, and except as specifically limited to herein, the renewal commissions shall be paid for the term and in the amount shown in the Schedule, so long as they exceed \$250 in a year, or you are receiving first year commissions. Vesting will cease if this Agreement is terminated for cause. If this Agreement terminates because you die, we will continue payments to your designated beneficiary. If no beneficiary is designated, we will pay your executor. Payments after your death will cease if the policyholder requests a new agent.

You authorize us to provide your production and earnings records to the Agent(s), if any, to whom you are assigned.

#### 6. GENERAL PROVISIONS

- a. **Errors and Omissions Coverage.** For as long as this Agreement is in force, you shall maintain Errors and Omissions insurance with a carrier in amounts and with a deductible that we accept. You agree to provide evidence that such coverage is in force upon our request for such evidence.
- b. **Personal Liability.** You agree to indemnify us and hold us harmless from all losses and expenses we incur resulting from your acts or omissions other than those which we so authorize in writing.
- c. **Advertising.** You shall comply with our advertising rules. You shall not use, permit, or cause to be used, our name or any advertising regarding our products without obtaining our prior written consent.
- d. **Expenses.** You agree to be solely responsible for all your expenses incurred in performing this Agreement.
- e. **Indebtedness.** Any amount you or your subagents owe us is a first lien on any compensation payable to you under this Agreement until the debt is fully paid. You agree that if at any time you have a debit balance with us, you are not due any compensation. Commissions will be credited to your account until such time as the debit balance has been cleared. Termination of this Agreement does not release you from continuing liability to us for immediate repayment of any debt including unearned first year commissions or bonuses. We have the right to charge interest at the maximum lawful rate on any outstanding debt.
- f. **Return of Premium.** If, for any reason, we refund premiums on which you received compensation, you agree to immediately repay us any compensation you received on that premium.
- g. **Waiver.** Failure of the Company to strictly enforce any provision of this Agreement will not be interpreted as a waiver of such provision.
- h. **Modification.** Any change to this Agreement must be in writing signed by an authorized officer of the Company.
- i. **Assurity Property.** You agree to return all of our property upon demand or at this Agreement's termination. Our property includes, without limitation, all rate books, manuals, supplies, applications, video materials, computer software, insured files and advertising and sales materials supplied by the Company and not owned by you.
- j. **Assignment.** You cannot assign this Agreement or compensation payable hereunder unless we agree in writing in advance.
- k. **Governing Law.** This Agreement is governed by and interpreted according to Nebraska law. All actions with respect to this Agreement shall be brought in a court of competent jurisdiction in Lancaster County, Nebraska.
- l. **Entire Agreement.** This Agreement including any attachments, schedules and addendums, supersedes any and all previous Agreements between you and the Company, and is the entire Agreement between you and the Company. If any provision of the Agreement is now or shall in the future be in conflict with any applicable law or any valid Department of Insurance ruling or order, it shall be modified to the extent necessary for compliance.

#### 7. ANTI-MONEY LAUNDERING

You agree to comply with all applicable anti-money laundering laws, regulations, rules and government guidance, including the reporting, record-keeping and compliance requirements of the Bank Secrecy Act ("BSA"), as amended by the USA PATRIOT Act (the "Patriot Act"). These Acts include requirements to identify and report currency transactions and suspicious activity, to implement a customer identification program to verify the identity of customers and to implement an anti-money laundering compliance program.

#### 8. PRIVACY (REQUIREMENTS PURSUANT TO THE GRAMM-LEACH BLILEY ACT AND STATE PRIVACY LAWS)

You agree to protect any confidential information of the Company's customers that is accessible by you. Confidential Information includes, but is not limited to any nonpublic personal information about the Company's customers or potential customers, regardless of whether it is personally identifiable or anonymous information. You agree, now and at all times in the future, not to use or disclose Confidential Information to any person or entity, other than to carry out the purposes for which the Company's applicant or customer disclosed the information, or as necessary to carry out the lawful business purposes of this Agreement, or as otherwise allowed by law or regulation. Your use or disclosure of Confidential Information shall comply at all times with federal and state privacy laws, rules and regulations.

#### 9. TERMINATION

Either party may terminate this Agreement at any time by giving written notice. Notice may be mailed or delivered to the last known address of the other party. If you reside in, or are licensed in, a state that requires advance notice, you hereby agree to waive any advance notice of termination and agree that termination will be effective immediately upon delivery of written notice. We may terminate this Agreement for cause if you commit any act that injures our business or reputation; fail to account for and remit promptly any monies collected by you for us; or withhold any policies, money or other property belonging or returnable to the Company.



**ASSURITY® LIFE INSURANCE COMPANY**  
**SUPPLEMENT TO AGENT AGREEMENT FOR SALES OF PRODUCTS SUBJECT TO HIPAA**

Accepted:

\_\_\_\_\_  
By: Signature of Agent or Firm Principal

\_\_\_\_\_  
Print or Type Name and Title Here

**ASSURITY LIFE INSURANCE COMPANY**

This Agreement is effective \_\_\_\_\_

Approved:

\_\_\_\_\_  
Company Officer

This Supplement is between the Agent who signed this Supplement (referred to as "you," "your," and/or "Agent" in this Supplement) and Assurity Life Insurance Company (we will be referred to as "Assurity," "our," "we," "us," and "the Company"). This Supplement amends and is a part of the Agent Agreement that you have with Assurity. The provisions stated in all supplements, commission rules, and schedule of commissions are incorporated into and made a part of this Agreement. Any references herein to "Agreement" refer to this Supplement. This Supplement shall become effective on the date shown above.

**1. PRIVACY (REQUIREMENTS RELATING TO PROTECTED HEALTH INFORMATION PURSUANT TO HIPAA).**

**1.1 Definitions.** *The following definitions relate to this section only.*

- a. **Business Associate.** "Business Associate" means a person who performs, or assists in the performance of, a function or activity involving the use or disclosure of individually identifiable health information, or any other function or activity regulated by the Privacy Rule.
- b. **Individual.** "Individual" means the person who is the subject of protected health information, or that person's personal representative in his or her fiduciary capacity.
- c. **Individually Identifiable Health Information** shall mean information that is a subset of health information, including demographic information collected from an individual, and (i) is created or received by a health care provider, health plan, health care clearinghouse (as those terms are defined in the Privacy Rule), or employer; and (ii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (a) identifies the individual, or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- d. **Privacy Rule.** "Privacy Rule" shall mean the Standards for Privacy of Individually identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E, as in effect or as amended.
- e. **Protected Health Information.** "Protected Health Information" shall mean Individually Identifiable Health Information transmitted or maintained in any form or medium that you create or receive from or on behalf of Assurity in the course of fulfilling its obligations under this Agreement. "Protected Health Information" shall not include (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. §1232g, and (ii) records described in 20 U.S.C. §1231g(a)(4)(B)(iv).
- f. **Required By Law.** "Required By Law" means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law.
- g. **Secretary.** "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

**1.2 Obligations and Activities.**

- a. You, as a Business Associate of Assurity, agree to comply with the duties and requirements placed upon Business Associates by the Privacy Rule or as otherwise Required by Law.
- b. You agree to comply with the policies and procedures of Assurity with respect to Protected Health Information.
- c. You agree to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.
- d. You agree to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- e. You agree to mitigate, to the extent practicable, any harmful effect that is known to you of a use or disclosure of Protected Health Information by you in violation of the requirements of this Agreement.
- f. You agree to report to Assurity any use or disclosure of the Protected Health Information not authorized or provided for by this Agreement of which you become aware, within thirty (30) days of becoming aware of such use or disclosure.
- g. You agree to ensure that any person or entity to whom you provide Protected Health Information received from Assurity or the Individual, or created or received by you on behalf of Assurity, agrees to the same restrictions and conditions that apply through this Agreement to you with respect to such information.
- h. You agree to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by you on behalf of Assurity available to Assurity, or to the Secretary, within ten (10) days of such request, or as designated by the Secretary, for purposes of the Secretary determining Assurity's compliance with the Privacy Rule.
- i. You shall keep a record of disclosures of Protected Health Information and agree to make information regarding disclosures of Protected Health Information available to Assurity within fifteen (15) days of a request by Assurity. You shall provide, at a minimum, the following information: (i) the date of disclosure; (ii) the name of the entity or person who received the Protected Health Information, and the address of such entity or person, if known; (iii) a brief description of the Protected Health Information disclosed; (iv) a brief statement regarding the purpose and explanation of the basis of such disclosure and (v) the names of all individuals whose Protected Health Information was disclosed.
- j. Within fifteen (15) business days of a request by Assurity, you agree to comply with Assurity's request to accommodate an individual's access to his/her Protected Health Information. In the event an individual contacts you directly about access to Protected Health Information, you will not provide access to the individual but shall forward such request to Assurity within five (5) business days of such contact.

- k. Within fifteen (15) business days of a request by Assurity, you agree to comply with Assurity's request to make amendments to Protected Health Information. You shall promptly incorporate any such amendments into the Protected Health Information. In the event an individual contacts you directly about making amendments to Protected Health Information, you will not make any amendments to the individual's Protected Health Information but shall forward such request to Assurity within five (5) business days of such contact.
- l. You agree to notify Assurity within five (5) business days of your receipt of any request, subpoena, or judicial or administrative order to disclose Protected Health Information. To the extent that Assurity decides to assume responsibility for challenging the validity of such request, subpoena or order, you agree to cooperate fully with Assurity in such challenge.
- m. If a customer terminates his or her relationship with you, or the customer's policy is not renewed or is canceled, you shall return to Assurity, or destroy, all Protected Health Information received from Assurity, or created or received by you from the customer. This provision shall apply to Protected Health Information that is in the possession of your employees, subcontractors, agents or associates. You shall retain no copies of the Protected Health Information.

1.3 Permitted Uses and Disclosures.

General Use and Disclosure Provisions.

Except as otherwise limited in this Agreement, you may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Assurity as specified in the Agreement provided that such use or disclosure would not violate the Privacy Rule if done by Assurity.

Specific Use and Disclosure Provisions

- a. Except as otherwise limited in this Agreement, you may use Protected Health Information for the proper management and administration of your business or to carry out your legal responsibilities.
- b. Except as otherwise limited in this Agreement, you may disclose Protected Health Information for the proper management and administration of your business, provided that disclosures are Required By Law, or you obtain reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies you of any instances of which it is aware in which the confidentiality of the information has been breached.
- c. You may use Protected Health Information to report violations of law to Assurity and to appropriate Federal and State authorities, where consistent with the Privacy Rule.

1.4 Obligations of Assurity.

To the extent that your use or disclosure of Protected Health Information may be affected, Assurity shall notify you of:

- a. Any limitation(s) in its notice of privacy practices of Assurity;
- b. Any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information.
- c. Any restriction to the use or disclosure of Protected Health Information that Assurity has agreed to.

1.5 Termination.

- a. Termination for Cause. Upon Assurity's knowledge of a material breach or violation of the requirements imposed by the Privacy Rule by you, Assurity may either:
- b. Provide an opportunity for you to cure the breach or end the violation and terminate this Agreement if you do not cure the breach or end the violation within the time specified by Assurity;
- c. Immediately terminate this Agreement if you have committed a material breach or violated the Privacy Rule and cure is not possible; or
- d. If neither termination nor cure are feasible, Assurity shall report the violation to the Secretary.

1.6 Effect of Termination.

- a. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, you shall return or destroy all Protected Health Information received from Assurity, or created or received by you on behalf of Assurity. This provision shall apply to Protected Health Information that is in the possession of your employees, subcontractors, agents or associates. You shall retain no copies of the Protected Health Information.
- b. In the event that you determine that returning or destroying the Protected Health Information is infeasible, you shall provide to Assurity notification of the conditions that make return or destruction infeasible. Upon written notice by you to Assurity that return or destruction of Protected Health Information is infeasible, you shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as you maintain such Protected Health Information.

1.7 Indemnification. You hereby agree to indemnify and hold Assurity, its employees, officers and directors harmless from and against any and all liability, payment, loss, cost, expense (including reasonable attorneys' fees and costs), or penalty incurred by Assurity, its employees, officers or directors in connection with any claim, suit, or action asserted against such entity or person resulting from the failure to fulfill any obligation imposed on you by the Privacy Rule by you or your employees, agents or subcontractors.

1.8 Injunction. You hereby agree that Assurity will suffer irreparable damage upon your breach of your obligations under the privacy provisions of this Agreement, and that such damages shall be difficult to quantify. You hereby agree that Assurity may file, and you will not contest, an action for an injunction to enforce such provisions against you, in addition to any other remedy Assurity may have.

1.9 Survival. Your respective rights and obligations relating to the requirements of the Privacy Rule and Protected Health Information shall survive the termination of this Agreement.

1.10 Interpretation. Any ambiguity in this Agreement shall be resolved to permit Assurity to comply with the Privacy Rule.