

Group Marketing Services, Inc.

P.O. BOX 19040 • Kalamazoo MI 49019-0040 • (269)343-2611

WAIVER OF PREMIUM (LIFE) CLAIM FORM

TO BE COMPLETED BY EMPLOYEE

1. EMPLOYEE'S NAME	2. SOCIAL SECURITY OR CERTIFICATE NUMBER	3. PHONE NUMBER
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4. CURRENT ADDRESS	CITY	STATE	ZIP CODE
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5. DATE OF BIRTH	6. OCCUPATION (LIST DUTIES OF YOUR OCCUPATION AT THE TIME OF DISABILITY)
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7. WHAT WORK DUTIES ARE YOU INCAPABLE OF PERFORMING?	8. ARE YOU CAPABLE OF PERFORMING ANY WORK?
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9. EMPLOYER'S NAME	10. INITIAL DATE OF INJURY OR SICKNESS
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11. LAST DAY WORKED	12. IF INJURY – HOW AND WHERE ACCIDENT OCCURRED
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13. Is this condition due to a work related injury? Yes No Currently Under Review Unknown

Has this claim been filed under worker's compensation coverage? Yes No

14. What types of activities are you capable of performing?

15. Have you applied for or are you receiving benefits from?

Social Security: Yes No Worker's Comp: Yes No Group Disability Benefit: Yes No Medicare: Yes No

If "Yes", List name(s) and address of organization or companies paying benefits, weekly or monthly benefits and date benefits commenced:

16. Have you ever had same or similar sickness or injury? Yes or No; If yes, Indicate Dates:

17. Name(s) and address of attending physicians (in last 2 years):

Name	Address	Treatment Dates

18. Hospital admission(s) due to disability:

Hospital Name	Address	Date Entered	Date Discharged

By furnishing this blank and investigating the claim, the Company shall not be held to admit the validity of any claim or waive the breach of any condition of the Policy. Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law. I hereby agree to reimburse Assurity Life Insurance Company (Assurity) to the extent of any overpayment which is in excess of the amounts payable under any Assurity insurance policy(ies). I hereby certify the statements above are complete and accurate to the best of my knowledge.

Employee Signature: _____ Date: _____

AUTHORIZATION

I, on behalf of myself or the person named above ("Claimant"), authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau ("MIB"), consumer reporting agency, employer, Social Security Administration, Internal Revenue Service, Veterans Administration or other organization or person that has any records or knowledge of me or my health to disclose to Assurity Life Insurance Company ("Company"); its reinsurers and/or consumer reporting agencies and their authorized representatives (provided, however, consumer reporting agencies may not collect information under this authorization from MIB):

- 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 maybe related directly or indirectly to sexual orientation), occupation, finances, avocations and other characteristics.
- Information on the diagnosis or treatment of Human Immuno deficiency Virus (HIV) infection and sexually transmitted diseases.
- Information on the diagnosis & treatment of mental illness & the use of alcohol, drugs, and tobacco, excluding psychotherapy notes.

I understand this information maybe released by the Company and/or its reinsurers to their consulting physicians, attorneys, MIB, and to other insurance companies in which the Claimant has policies or to whom claims for benefits have been made or maybe submitted.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information of the Claimant do not apply to this authorization and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose the Claimant's entire medical record as described above without restriction. The medical information so acquired will be used to determine eligibility for benefits under a policy. I understand that when information is used or disclosed pursuant to this authorization, it maybe subject to re-disclosure and may no longer be protected by the federal rules governing privacy of health information. This authorization is valid for twelve (12) months from the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by providing written notice to the Company. I understand that a revocation is not effective to the extent that action has been taken in reliance on this authorization. I understand that I may refuse to sign this authorization and that such refusal to sign will not affect the ability of the Claimant to obtain treatment. I further understand that if I refuse to sign this authorization, Company may not be able to make any benefit payments.

I understand that I will receive a copy of this authorization upon request and that a photographic copy of this authorization shall be as valid as the original.

Signature of Insured or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Insured: _____