



## Final Expense Paperless Application Process Instructions

Agents will no longer be required to fill out an Application, HIPAA and Disclosure Forms and Bank Draft Forms and submit these to new business! **It's EZ as 1 - 2 - 3!**

1. **The Agent** makes the final expense sale with client. Using the ***application worksheet, Child/Grandchild Supplemental Application***, along with the ***Disclosure Form***, the Agent should:
  - a. Pre-Qualify the client, and Children and/or Grandchildren (if applicable), for the correct plan using the health questions as a guideline.
  - b. Gather important client personal and Bank account information.
  - c. Have all the required disclosures, including HIPAA, to read and give the client in one easy detached form. Included is a conditional receipt should you collect the first premium!
2. **Once worksheet is completed and disclosures read, the Agent** will make the call to **DIMA** (800-604-6844) to initiate the Point of Sale Telephone Interview (**POSTI**) for instant underwriting decision ***AND*** application paperwork completion! Information from the worksheet, and Child//Grandchild Supp App (if applicable) will be required during this interview from the agent. ***Complete and accurate data will make the call smooth and timely.***

***Please Note: By eliminating the need to fill out and then send in all paperwork, the time will more than offset the few additional minutes required in the paperless process. The worksheet will allow an agent to have important client and bank information readily available for the Telephone Interview.***

**DIMA** will begin the process as follows:

- a. Ask the Agent client personal and Bank information.
  - b. Speak with your client to obtain, verify, and underwrite the sale. This includes:
    - i. Verify disclosures have been read or given to client, including MIB and HIPAA.
    - ii. Obtain voice signatures for disclosures and application.
    - iii. Verify health questions (same as worksheet).
    - iv. Complete Application and all required Forms.
    - v. Give the Agent an **instant underwriting decision** before you hang up!
    - vi. Instruct DIMA where the policy should be sent: To the Agent or Client.
3. **The Agent** retains the worksheet for their record.....NO need to send in anything and the client's policy will be issued. **EXCEPT FOR THE FOLLOWING:**
    - a. **If the sale is a replacement:** The proper state required replacement form(s) must be completed and signed prior to the call to DIMA.
    - b. **Alabama:** Alabama Arbitration Disclosure Form (#CLIC-ARB-AL)
    - c. **California:** Medical Eligibility Disclosure (#7404.4-0505) Home Meeting Disclosure for 65 & Over (7404.2-0505) Financial Product Disclosure 65 & Over (7404.3-0505)
    - d. **Pennsylvania:** Disclosure Statement (LBL PA DIS (0806)

**Agent must note POSTI reference # on the upper right corner for any required form and fax to new business @888-525-5002. Failure to do so will delay policy issue and commissions paid.**



Liberty Bankers Life  
The Capitol Life

Check  
Appropriate  
Company

**Final Expense  
Pre-Qualifying Worksheet**

PO Box 224 Brownwood, Texas 76804-0224 • 1-888-525-4467 • FAX 1-888-525-5002 • E-Mail: newbiz@lbidadmin.com

**This worksheet is necessary to initiate underwriting. Please complete all information before you call DIMA.** Once form is completed, please call 800-604-6844 for the application and approval completion process. Agent, Insured, (Owner and/or Payor, if different) must be on the phone at the time of the call. This worksheet contains sensitive information and should be kept secured for your records or destroyed. **Do not send in this form.**

Agent: \_\_\_\_\_ Agent Number \_\_\_\_\_ Date: \_\_\_\_\_  
 POSTI Reference #: \_\_\_\_\_ Issue State: \_\_\_\_\_ Telesales application  YES  NO

**Proposed Insured Full Name:**  
 \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Present Age \_\_\_\_\_  
 Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 State of Birth \_\_\_\_\_ Country of Birth \_\_\_\_\_  
 Social Security No. or ITIN \_\_\_\_\_  
 Have you used tobacco, nicotine, or e-cigarettes in any form in the past 12 months?  YES  NO  
 Name and City of Doctor: \_\_\_\_\_  
 Are You Currently Disabled?  YES  NO  
 If Yes, Please provide details: \_\_\_\_\_  
 \*\*\*\*\*  
 Street Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Home/Cell Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_

**Plan- Riders Applied For:**  
 Face Amount \$ \_\_\_\_\_  
 \_\_\_ SIMPL Preferred \_\_\_ SIMPL Standard \_\_\_ MWL  
 \_\_\_ AD&D \_\_\_(units) CTIR \_\_\_ Grandchild Rider  
 Premium Amount \$ \_\_\_\_\_ Premium Mode:  
 Monthly Bank Draft **OR**  
 Quarterly  Semi-Annual  
 Annual Amount Paid with Application  
 \$ \_\_\_\_\_

**OWNER OF POLICY IF NOT INSURED:**  
 \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Social Security No. \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home/Cell Phone \_\_\_\_\_

**Check here to draft first premium**  
**Bank Draft Date Each Month**  
 1<sup>st</sup> of Month  3<sup>d</sup> of Month  
 2<sup>nd</sup> Wednesday  3<sup>rd</sup> Wednesday  
 4<sup>th</sup> Wednesday  Other Date: \_\_\_\_\_

**Primary Beneficiary** \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Home/Cell Phone \_\_\_\_\_  
**Contingent Beneficiary** \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Home/Cell Phone \_\_\_\_\_

**Name as it Appears on Bank Acct:**  
 \_\_\_\_\_  
**Acct. #** \_\_\_\_\_  
**Routing #:** \_\_\_\_\_

**Bank Information Name of Financial Institution:**  
 \_\_\_\_\_  
**City:** \_\_\_\_\_  
**State:** \_\_\_\_\_

**Replacement Information: (Replacement not allowed for tele-sales)**

YES NO

1. Does proposed Insured have existing life insurance policies or annuity contracts?.....
2. Will this insurance replace or change any other insurance policies or annuity contracts? .....

If “Yes” to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required:\_\_\_\_\_

**Use the following health questions to decide which Final Expense plan to offer****If the applicant answers “Yes” to any question in Part 1, DO NOT PROCEED with the application.****Part 1**

YES NO

Have you ever been diagnosed have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

1. Congestive heart failure (CHF), cardiomyopathy, memory loss, Alzheimer’s, senile dementia, dementia, heart defibrillator implant, two or more instances of internal cancer(s) or terminal illness (terminal illness means a disease or illness that is expected to result in death within 24 months)? .....
2. Organ transplant (other than corneal), untreated Hepatitis C, kidney failure or dialysis, amputation due to diabetic complications, multiple sclerosis, muscular dystrophy, mental retardation, amyotrophic lateral sclerosis (ALS) or Lou Gehrig’s disease, Downs’s syndrome, cystic fibrosis or Huntington’s disease?.....
3. Diabetes at age 9 or younger?.....
4. AIDS, AIDS Related Complex, tested positive for HIV virus or any other disorder of the immune system? .....

Within last 2 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

5. Uncontrolled diabetes or uncontrolled high blood pressure?.....

Within the last year have you:

6. Been confined to a hospital, been advised by a member of the medical profession to have surgery or hospitalization, used oxygen due to a medical condition, been unable to care for yourself or been prescribed bed rest by a member of the medical profession at home or in a nursing home, hospice, long-term care or assisted living facility? Definition of assisted living: requires help in at least one area of skills considered necessary for living and caring for oneself (feeding, dressing or bathing).....

**If all “No” answers in Part 1, complete Part 2.****Part 2 Complete all questions and circle the condition(s) to which each “Yes” answer, if any, applies.**

YES NO

Within the past 2 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

- (a) Angina (chest pain), any type of heart or circulatory surgery, heart attack, or received a pacemaker or stent?.
- (b) Stroke, Transient Ischemic Attack (TIA/mini-stroke) or paralysis?.....
- (c) Cancer or received or been advised to receive chemotherapy or radiation for cancer (the term “cancer” includes melanoma, but excludes basal cell skin cancer)?.....
- (d) Aneurysm, brain tumor or sickle cell anemia? .....
- (e) Complications of diabetes such as nephropathy (kidney), neuropathy (nerve, circulatory), retinopathy (eye) diabetic coma or insulin shock? .....
- (f) Alcohol or drug abuse, have you used illegal drugs or been convicted of felony or on parole? .....
- (g) Used a walker, wheelchair or electric scooter due to chronic illness or disease?.....

**If all “No” answers in Part 2, complete Part 3. Otherwise, select MWL & check for state availability.****Part 3 Complete all questions and circle the condition(s) to which each “Yes” answer, if any, applies.**

YES NO

Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

- (a) Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, emphysema, peripheral vascular disease or peripheral artery disease? .....
- (b) Chronic hepatitis, Hepatitis C, cirrhosis of the liver, chronic pancreatitis, liver disease or kidney disease? .....
- (c) Insulin use before age 25? .....
- (d) Irregular heartbeat, atrial fibrillation, Systemic Lupus (SLE), epileptic seizures, Parkinson’s disease? .....

**If all “No” answers in Part 3, select SIMPL Preferred. Otherwise, select SIMPL Standard.****AGENT NOTES:**

<b>1. Supplement to Application on :</b>			<b>Check Appropriate Rider</b>	
<b>Proposed Insured:</b>	<b>Application Date:</b>	<b>Policy # (When adding existing rider)</b>	<b>Child Rider # of units</b> <input type="radio"/>	<b>Grandchild Rider \$7,500</b> <input type="radio"/>
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>	

**2. Children/Grandchild Proposed for Insurance (Please Print)**

*Name all natural-born children, stepchildren and legally adopted children or grandchildren for grandchild rider of Primary Proposed Insured who have not attained age 18. Insurance will not be provided on newborn children less than 15 days of age or grandchildren if grandchild riders applied for. (Attach another sheet if necessary):*

Full Name of Proposed Insured Child/Grandchild	Age Last Birthday	Sex	Date of Birth	Relationship to Proposed Insured	Height	Weight
A.						
B.						
C.						

**3. Health Information**

- Has any Proposed Insured Child/Grandchild ever had, been diagnosed or treated for cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, mental retardation, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorders of the muscles or bones, anemia or other disorders of the blood, bladder, kidneys, liver or lungs?.....  Yes  No
- Has any Proposed Insured Child/Grandchild ever had, been diagnosed or treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) ?.....  Yes  No
- Has any Proposed Insured Child/Grandchild ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?.....  Yes  No

**Please provide details to any "Yes" answer to Question 1-3 (Attach another sheet if necessary):**

Proposed Insured Child/Grandchild	Condition & Treatment	Date	Name & Address of Physician or Hospital

**Beneficiary Designation:**

*Any proceeds payable under this rider will be paid to the Owner, if living. Otherwise, per the beneficiary provision of the rider.*

- Does Proposed Insured Child/Grandchild have existing life insurance policies or annuity contracts?....  YES  NO
  - Will this insurance replace or change any other insurance policies or annuity contracts? .....  YES  NO
- If "YES" to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required: \_\_\_\_\_

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application  
Dated at \_\_\_\_\_, \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_.

Signature of Grandparent/Parent Guardian \_\_\_\_\_ (e-signed)

*The electronic signature(s) above fully comply with the Federal Electronic Signature status, Title 15, U.S.C., Chap. 96, Sec. 7001, et seq., and is therefore fully legal and valid as an original signature.*

**Agent Statement:**

- Does the Proposed Insured have any existing life insurance policies or annuity contracts?.....  YES  NO
- Is replacement of existing insurance involved in this application? If yes: Have you submitted the appropriate replacement forms?.....  YES  NO

Signature of Agent: \_\_\_\_\_ (e-signed) Agent Number \_\_\_\_\_



**DISCLOSURES for PAPERLESS APPLICATION PROCESS – GENERIC**

Included are the three required disclosures (Fair Credit, MIB, and HIPAA) that must be read and given to your applicant prior to the point of sale telephone interview (POSTI). For SIMPL Standard and Preferred plans only, an Accelerated Death Benefit disclosure must also be read and given to the applicant prior to the point of sale telephone interview. Your client will be asked to verify that these were read to them. In addition, the states of Alabama, California, and Pennsylvania require state specific disclosures that must be completed, signed, and faxed to New Business prior to issuing a policy. These state required forms may be obtained from the website in the Forms Portal. Agent must note POSTI reference # on the upper right corner for any required form and fax to new business @888-525-5002.

**In addition, included is a conditional receipt should you collect the correct first premium mode.**

**This Notice Must be Given to Proposed Insured**

**FAIR CREDIT REPORTING ACT PRE-NOTIFICATION FORM.** Thank you for considering Liberty Bankers/The Capitol Life Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-5088 requires that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors, and associates. You are entitled to be interviewed in connection with an investigative consumer report; and, you have the right to receive a copy of any investigative consumer report by making a written request within a reasonable period of time.

**NOTICE TO APPLICANTS FOR INSURANCE.** Information regarding your insurability will be treated as confidential. Liberty Bankers/The Capitol Life Insurance Company, or its reinsurer(s), may, however, make a brief report of my protected health information to the MIB, Inc., a not for profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request from you, will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB, Inc. and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts, 02184, telephone 1-866-692-6901, web address: [www.mib.com](http://www.mib.com). Liberty Bankers/The Capitol Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

**CONDITIONAL RECEIPT – (Cross through if payment is NOT received).**

**NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY, UNLESS THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY: INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ONLY IF THESE CONDITIONS ARE MET:**

- 1. That on the effective date the Proposed Insured is insurable as a standard risk under the Company's rules for the plan amount and premium rate applied for.
- 2. That the sum paid is equal to the FULL FIRST PREMIUM for the policy applied for.

**INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ON THE LATEST OF:**

(a) date of the application; or (b) date requested in the application; or  
(c) date of the last of any medical examinations or tests required under the rules and practices of the Company.  
The total amount of insurance which may become effective prior to delivery of the policy to the Owner shall not exceed \$25,000. This amount includes LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS then IN FORCE or APPLIED FOR with this Company. **LIBERTY BANKERS/THE CAPITOL LIFE INSURANCE COMPANY** has received \$ \_\_\_\_\_ for Applicant \_\_\_\_\_

X \_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Date

**THE PREMIUM CHECK MUST BE MADE PAYABLE TO LIBERTY BANKERS/THE CAPITOL LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**



Administrative Office: P O Box 224  
Brownwood, Texas 76804  
1-800-604-8002

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any: medical practitioner, physician, hospital, clinic, pharmacy benefit manager, or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on LIBERTY BANKERS LIFE INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, pharmacy prescription drugs, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that LIBERTY BANKERS LIFE underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I authorize LIBERTY BANKERS LIFE INSURANCE COMPANY, or its reinsurers, to make a brief report of my protected health information to the MIB, Inc.

I understand that:

- such information will be used by LIBERTY BANKERS LIFE INSURANCE COMPANY for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- a picture copy or photocopy of this authorization shall be as valid as the original; and
- any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of LIBERTY BANKERS LIFE INSURANCE COMPANY, P. O. Box 224, Brownwood, Texas 76804. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Proposed Insured (Please print)

\_\_\_\_\_  
Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Additional Proposed Insured (Please print)

\_\_\_\_\_  
Signature of Additional Person Proposed for Insurance

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Personal Representative designated by signature above is hereby authorized to execute this instrument based on:  
power of attorney, guardian-in-fact, guardian, payee,  
representative, other \_\_\_\_\_ (Circle one)

# Liberty Bankers Life Insurance Company

## ACCELERATED DEATH BENEFIT PAYMENT RIDER DISCLOSURE

**NOTICE: Death benefits, premium payments, and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider do not and are not intended to qualify as long-term care insurance. The accelerated benefits offered under this rider are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.**

### **PREMIUMS**

There is no premium charge for the accelerated death benefit rider.

### **EFFECT ON POLICY VALUES**

After payment of the accelerated death benefit, the death benefit of the policy will be reduced by the amount of accelerated death benefit. Any premium payments, cash values, and other obligations and benefits under this policy, excluding that for riders, will be reduced proportionately. Upon a request to accelerate benefits under this rider, the owner and any irrevocable beneficiary will be given a statement demonstrating the effect of the acceleration of benefits on the cash value, death benefit, premium charges, and policy loans.

### **AMENDED POLICY SCHEDULE**

An amended policy schedule will be sent to you, the owner, and any irrevocable beneficiary upon a request to accelerate benefits and upon payment of this benefit. The schedule will show the reduced death benefit, cash value and premium amounts.

### **ACCELERATED BENEFIT**

A benefit that may be requested by the owner if the insured is terminally ill, or if the insured is chronically ill. Terminal Illness and Chronic Illness are defined below.

### **MAXIMUM ACCELERATED DEATH BENEFIT**

The sum of all accelerated benefit payments may not exceed the smaller of \$250,000 or 80% of the face amount.

### **CONDITION OF PAYMENT**

We will pay an amount up to the maximum accelerated death benefit if we receive proof that the insured (a) has been diagnosed with a terminal illness; or (b) is chronically ill. An administrative expense charge and an interest charge may apply at the time of acceleration.

### **DEFINITION OF TERMINAL ILLNESS**

Terminal illness is considered a disease or illness that is expected to result in the death of the insured within twelve (12) months.

### **DEFINITION OF CHRONIC ILLNESS**

Chronic illness is considered a disease or illness such that the insured is unable to perform at least two activities of daily living or requires substantial supervision as protections from threats to health or safety.

**CERTIFICATION OF PHYSICIAN**

The certification by a physician must include documentation supported by clinical, radiological, histological, or laboratory evidence of the condition.

**PHYSICIAN OF OUR CHOICE**

We may require an additional examination by a physician of our choice, and at our expense. If there is a conflict of medical opinion as to the life expectancy of the insured, a third medical opinion that is provided by a physician that is mutually acceptable to the insured and the company will govern.

I have received a copy of this disclosure.

X  
Applicant

\_\_\_\_\_  
Date

X  
Agent

\_\_\_\_\_  
Date