Liberty Bankers Life
The Capitol Life

# 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@lbladmin.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**

☐ **1st of Month** ☐ **3d of Month**

☐ **2nd Wednesday** ☐ **3rd Wednesday**

☐ **4th 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:** _____

SIMPL WORKSHEET 09-2017

**FOR AGENTS USE ONLY!**

**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:**

*Application to Liberty Bankers Life Insurance*
*P.O. Box 224 Brownwood, TX 76804*

*Supplemental Application for:*
*Children or Grandchild Rider*

| **1. Supplement to Application on:** | | | **Check Appropriate Rider** | |
|---|---|---|---|---|
| **Proposed Insured:** | **Application Date:** | **Policy # (When adding existing rider)** | **Child Rider # of units** ☐ | **Grandchild Rider $7,500** ☐ |
| **Address** | **City** | **State** | **Zip Code** | |

**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**

1. 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
2. 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
3. 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.*

1. Does Proposed Insured Child/Grandchild have existing life insurance policies or annuity contracts?.... ☐ YES ☐ NO
2. 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:**

1. Does the Proposed Insured have any existing life insurance policies or annuity contracts?..... ☐ YES ☐ NO
2. 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 _____

Liberty Bankers Life
The Capitol Life

# 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.**

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**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. 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.

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**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 CAPTIOL 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.**

Liberty Bankers Life
Insurance Company

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 | | X | |
|---|---|---|---|
| Applicant | Date | Agent | Date |

Liberty Bankers Life
Insurance Company

**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
The Capitol Life

**NEW**
09/01/2010

**Automatic Bank Draft**

*P.O. Box 224 Brownwood, TX 76804  1 (888) 525-4467*

## Premium Payments as Easy as ABC
(**A**utomatic **B**ank **C**hecking)

**Save the Hassle**. With **ABC**, you let LBL/CLIC and your financial institution handle your premium payments. Select the **ABC** option, and your future premiums will be withdrawn directly from your account and sent to us for timely processing.

---

## Authorization to Pay Future Monthly Premiums by ABC
(**A**utomatic **B**ank **C**hecking)

I authorize my Financial Institution to pay my insurance or annuity premiums through monthly checks, share drafts or electronic account debits drawn by and payable to Liberty Bankers/The Capitol Life Insurance Company. As my Financial Institution, you will be fully protected in honoring these payments until you receive written notice from me canceling this request.

Scheduled Payment Amount $ _____ Scheduled Payment Dates:_____

Account Name:_____ ☐ Checking ☐ Savings

Transit Number: _____ Account Number:_____

Financial Institution Name & Address:_____

**I have paid the initial premium by check, please draft future payments on the scheduled payment date shown above after policy approval.**

**Signature:**_____ **Date:**_____

**********

***Only complete this bottom section if NO premium has been collected!***

## FIRST PREMIUM BY BANK DRAFT
**(Select one option to initiate your first premium draft)**

1. _____ (initial here) Bank Draft my account **IMMEDIATELY** upon receipt of this pending application, and then on the scheduled payment date shown above after policy approval.
2. _____ (initial here) Bank Draft my account only when the policy is **APPROVED** for issue and thereafter on the scheduled payment date shown above.
3. _____ (initial here) **WAIT** to Bank Draft my account on the **FIRST Scheduled Payment Date** listed above following the policy approval.

_____ _____
Signature Date

 **Please attach a VOIDED CHECK to this form.**

**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;
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_____
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
The Capitol Life
P.O. Box 224 Brownwood, Texas 76804 1(800) 604-8002

**NAIC Replacement**

# IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

**This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.**
You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a few life insurance policies involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise termination your existing policy or contract? _____Yes _____No

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____Yes _____No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contact will be replace or used as a source of financing:

| | INSURER NAME | CONTRACT OR POLICY # | INSURED OR ANNUITANT | REPLACED ® OR FINANCING (F) |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. (If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.
The existing policy or contract is being replaced because ._____
I certify the responses herein are, to the best of my knowledge, accurate:

| | | |
|---|---|---|
| Applicant's Signature | Printed Name | Date |
| Producer's Signature | Printed Name | Date |

I do not want this notice read aloud to me._____ (Applicants must initial only if they do not want the notice read out loud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older - are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

# REPLACEMENT TRANSACTION
# SALES MATERIAL CERTIFICATION STATEMENT

Print Producer Name and Number:_____

Print Applicant Name:_____

I hereby certify that:

- I used only insurer-approved sales materials;
- Copies of all sales materials used during solicitation were left with the applicant;
- Copies of all sales illustrations used during the solicitation were left with the applicant and also sent to the Home Office for the policy file; and
- This replacement is in compliance with the insurer's replacements guidelines.

_____ _____

Agent's Signature Date

I hereby certify that no sales materials or illustrations were used.

_____ _____

Agent's Signature Date