Liberty Bankers Life
Insurance Company

PO Box 224 Brownwood, TX 76804-0224
1-888-525-4467 ● FAX 1-888-525-5002 ● E-Mail: newbiz@lbladmin.com

APPLICATION PART I

1. Primary Proposed Insured (Please print full name)			6. Date of Birth Month Day Year	7. Birth Place (State or Country)
2. Address (Street)			8. Age	9. State of Issue & Drivers Lic. #
City	State	Zip Code	10. Occupation	11. Employer
3. Sex ☐ M ☐ F	4. Soc. Sec. No.	5. Home Phone No. ( ) -	12. Annual Income $	13. Net Worth $

COVERAGE DETAILS

14. Plan Name	15. Amount	16. Benefits/Riders
	$	☐ Child Term Rider ☐ Grandchild Rider* ☐ ALBR **(*Supplemental App must be submitted for GC rider)** ☐ AD&D $_____ ☐ WP ☐ Other _____

17. Child(ren) Rider

Full Name	Date of Birth	Age	Sex	Amount	Relationship	Height	Weight

18. Owner (if other than Primary Proposed Insured)
Name_____ Address_____
Relationship_____ Social Security No._____

19. Beneficiary

Primary _____ (Full Name) _____ (Relationship)

Contingent _____ (Full Name) _____ (Relationship)

20. Premium Amount: _____

Premium Mode:
☐ Monthly Bank Draft Draft Day:_____
☐ Check here to draft first premium
☐ Monthly List Bill ☐ Bi-Weekly
☐ Payroll Deduction ☐ Quarterly
☐ Semi-Annual ☐ Annual

	YES	NO
21. Existing Life Insurance or annuity contracts?	☐	☐
Is replacement of existing insurance involved in this application?	☐	☐
If yes: Have you submitted the appropriate replacement forms?	☐	☐

Name of Company	Date of Issue	Life Amount	Purpose Business/Personal	Accidental Death Benefit Amount	Replacement YES	Replacement NO
					☐	☐
					☐	☐
					☐	☐

(If there is additional insurance beyond those listed, please list on a separate sheet)

APPLICATION PART 2

Please provide details to "Yes" answers in Remarks Section

	YES	NO
22. Has Primary Proposed Insured used tobacco in any form in the past 12 months?	☐	☐
23. Has any Proposed Insured within the past 5 years		
a) Been charged with a driving while impaired (alcohol, drug, other) violation, had a drivers license revoked or suspended or within the last 24 months received 3 or more citations for moving traffic violations?	☐	☐
b) Had an application for insurance declined, rated, or postponed?	☐	☐
c) Flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so?	☐	☐
d) Engaged in parachuting, racing or other hazardous sport or intend to do so?	☐	☐
e) Used intravenous drugs, cocaine, barbiturates, hallucinogens, sought advice or treatment for alcohol or drug use?	☐	☐
24. Does any Proposed Insured intend to reside outside the U.S.?	☐	☐
25. Has any Proposed Insured ever been convicted of a felony or been incarcerated?	☐	☐

26. A) Primary Proposed Insured:

Height	Weight	Change in Past Year?	Cause of Weight Gain/Loss
_____	_____	_____Lbs. ☐ Gain ☐ Loss	

B) Name and Address of personal doctor?_____

C) Date and reason of last doctor visit, include any treatment given, medication prescribed, and results of visit._____

_____

27. Has any Proposed Life Insured, ever had, or been told they had, or received treatment or advice for:

	YES	NO
a) abnormal or high blood pressure, coronary artery disease or any other disorder or disease of the heart, blood vessels or cardiovascular system?	☐	☐
b) cancer, tumor, or any other growth or malignancy?	☐	☐
c) diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder?	☐	☐
d) any nose, throat, lung, or any other respiratory disorder?	☐	☐
e) any disorder of the stomach, intestines, rectum, liver, or pancreas?	☐	☐
f) any injury to or disease of the bones, muscles, joints, eyes, or skin?	☐	☐
g) epilepsy, seizures, brain disorder, or any other disease or disorder of the nervous system?	☐	☐
h) anxiety, depression, or an emotional, behavioral, mental or nervous disorder?	☐	☐
i) any disease or disorder of the kidney, bladder, or genital organs or system?	☐	☐
j) AIDS (acquired immune deficiency syndrome), positive HIV test, or any other immunological disorder?	☐	☐
28 Other than as stated above, has any Proposed Life Insured, within the past 5 years:		
a) Consulted, received treatment or advice from, been prescribed medication by any other medical advisor?	☐	☐
b) Had any abnormal diagnostic tests?	☐	☐
c) Been aware of any symptoms for which a medical advisor has not yet been consulted?	☐	☐
d) Used a wheelchair or walker on a permanent basis?	☐	☐
29. Has any of Proposed Life Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, stroke, or any other hereditary disease?	☐	☐

(If "Yes", indicate family member, illness, age at onset of illness and, if applicable, age at death).

30. REMARKS **(Explain "Yes" answers to Questions 22-29)**

Name of Person(s)	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

_____

_____

_____

_____

_____

PROPOSED INSURED'S NAME IN FULL **APPLICATION PART 3**

AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT –LIBERTY BANKERS LIFE INSURANCE COMPANY

I, the Primary Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereafter

AGREE to the following.

(a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.

(b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is Delivered while the health of any proposed insured continues, without material change, to be as represented in this application.

(c) No agent has authority to waive any answer or otherwise modify this application or to bind Liberty Bankers Life Insurance Company, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this Application.

(d) $_____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

AUTHORIZE any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance or Reinsuring company, the MIB, Inc. ("MIB"), consumer reporting agency, or any other organization, Institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, Treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about pharmacy prescription drugs, drugs, or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or Organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully Required or as I may further authorize. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 30 months from the date shown below. I know that I or my representative may request a copy of this authorization.

ACKNOWLEDGE receipt of the following notices

(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and

(b) MIB, Inc. Pre-Notice

Signed at _____, _____ _____

City State Date

X)_____ X)_____

SIGNATURE OF PRIMARY PROPOSED INSURED (IF AGE 16 OR OVER) OR PARENT OR GUARDIAN (JUVENILE APPLICATIONS)

SIGNATURE OF OWNER & RELATIONSHIP (IF OTHER THAN PRIMARY PROPOSED INSURED)

_____ X) _____

AGENT'S NAME (Printed, typed or stamped)

AGENT'S SIGNATURE

A person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false Information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

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LIBERTY BANKERS LIFE INSURANCE COMPANY

CONDITIONAL RECEIPT

TERMS AND CONDITIONS - coverage issued bearing the date of this receipt will become effective on the date of the application or last medical examination, whichever is later. Coverage will be provided when the following conditions are met.

1. The application and required information is received at our Home Office.
2. All persons proposed for coverage are insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid in cash on the date of application. The maximum amount of life insurance, including accidental death, which will become effective under this receipt, cannot exceed $100,000. This includes any previously pending insurance.

If the Policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first premium must be paid. If the application is declined or not approved within sixty days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

LIBERTY BANKERS LIFE INSURANCE COMPANY

LIFE Plan _____ **Amount $**_____

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

By_____ _____ 20____

Representing Company Date

AGENT'S REPORT

1. Agent Checklist (Provide details in Additional Remarks Section below)	**YES**	**NO**
A. Did you give the applicant a copy of the Privacy Notice and other disclosure information?	☐	☐
B. Are you related to the Proposed Insured?	☐	☐
C. Was this application taken in person?	☐	☐
D. Do you know anything not disclosed which might affect the underwriting of this risk?	☐	☐
E. Is there another application currently pending or being submitted to any other life insurance company?	☐	☐
F. Has any Proposed Insured applied elsewhere for any insurance coverage within the past 6 months?	☐	☐
G. Does the Proposed Insured have any existing life insurance policies or annuity contracts?	☐	☐
H. Is replacement of existing insurance involved in this application? If yes: Have you submitted the appropriate replacement forms?	☐	☐

2. Financial and Medical Requirement Information:	**YES**	**NO**
A. Have you informed the applicant that he/she may be called for an appointment?	☐	☐

3. Information for Business Insurance (e.g., Buy/Sell, Split Dollar, Key Person, etc.)	**YES**	**NO**
A. Is this insurance part of a split dollar agreement?	☐	☐
E. Are other key individuals applying? If yes, indicate name of each person. If no, for what reason?	☐	☐

B. The business operates as a:

☐ Regular Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship

C. What is the value of the business? $_____

D. What percentage does the Proposed Insured own or control? _____%

(indicate below) _____

4. Additional Remarks

_____

I certify I have accurately recorded all information given by the Proposed Insured and my statements on this Agent's Report are correct to the best of my knowledge. I claim full credit for this application unless other instructions are given below.

Date _____ **Agency** _____ **Code** _____

Agent's Name Signature X)_____ **Code** _____

Agent's Name Signature X)_____ **Code** _____

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NOTICE OF INFORMATION PRACTICES **This Notice Must be Given to Proposed Insured**

(Including MIB, Inc. Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or otherwise with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MIB, INC.

Information regarding your insurability will be treated as confidential. **LIBERTY BANKERS LIFE INSURANCE COMPANY** or its Reinsurer 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 or health insurance coverage, or a claim for benefits is submitted to such a Company, the MIB, Inc., upon request, will supply such Company with the information it may have in its file.

Upon receipt of a request from you, the MIB, Inc. will arrange disclosure of 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 procedures 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 LIFE INSURANCE COMPANY, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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.

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

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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)