Liberty Bankers Life Insurance Company

# Application for Individual Life Insurance "Simplified Issue Market"

[P.O. Box 224 Brownwood, Texas 76804-0224 ● 1-888-525-4467 ● FAX 1-888-525-5002 ● E-Mail: newbiz@lbladmin.com]

**All information must be provided to avoid delays. All questions are important, please read and complete each question.**

**Proposed INSURED (First Name, Initial, Last Name, Suf.):**

_____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

State of Birth _____ Country of Birth _____

Social Security No. or ITIN _____

Street Address _____

City, State, Zip _____

Mobile Phone _____

Other Phone _____

E-Mail _____

Occupation _____

Physician Name _____

City/State/Phone _____

**Plan Applied For:** □ SIMPL Pref. □ SIMPL Std.
□ MWL (no Riders) □ OTHER_____

Have you used tobacco, nicotine, or e-cigarettes in any form in the past 12 months? □ YES □ NO

Telesales application □ YES □ NO

Face Amount $_____

**Riders Applied for**:

□ Accidental Death & Dismemberment $_____

□ Waiver of Premium

☒ Accelerated Death Benefit (SIMPL ONLY)

□ Children's Benefit (attach supplemental application)

□ Grandchildren's Benefit (attach supplemental application)

**Premium Amount** (incl. any riders) $_____

**Premium Mode and Frequency**:

□ Monthly Bank Draft □ Direct Express Card
Draft Day_____ Load Day_____

□ Check here to draft first premium

□ Monthly List Bill □ Bi-Weekly

□ Payroll Deduction □ Quarterly

□ Semi-Annual □ Annual

**Primary Beneficiary** _____

Relationship _____

Street Address _____

Mobile Phone _____

E-Mail: _____

**Proposed OWNER (if other than Proposed Insured) (First Name, Initial, Last Name, Suffix):**

_____

Relationship to Proposed Insured _____

Social Security No._____

Street Address _____

City, State, Zip_____

Mobile Phone _____

E-Mail _____

**Contingent Beneficiary** _____

Relationship _____

Street Address _____

Mobile Phone _____

E-Mail _____

1. Does Proposed Insured 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:_____

**Please read each question carefully and answer truthfully before signing application.**
**If the applicant answers "Yes" to any question in Part 1, STOP with the application.**

**Part 1 – All Health Questions Must be Answered by Proposed Insured.**

| Have you, the Proposed Insured, ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: | YES | NO |
|---|---|---|
| 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' syndrome, cystic fibrosis, or Huntington's disease? | □ | □ |
| 3. Diabetes at age 9 or younger? | □ | □ |
| 4. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, tested positive for human immunodeficiency viruses (HIV), 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 to have surgery or hospitalization, used oxygen due to a medical condition, been unable to care for yourself or been bedridden 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, Proposed Insured should complete Part 2.**

**Part 2 Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.**

| Within the past 2 years have you, the Proposed Insured, been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: | YES | NO |
|---|---|---|
| (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, illegal use of drugs? | □ | □ |
| (g) Use of a walker, wheelchair, or electric scooter due to chronic illness or disease? | □ | □ |
| Within the past 2 years have you been convicted of felony, jailed, or on parole? | □ | □ |

**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.**

| Have you, the Proposed Insured, ever been diagnosed with, or received, or been advised to receive treatment or medication for: | YES | NO |
|---|---|---|
| (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, or Parkinson's disease? | □ | □ |

**If all 'No" answers in Part 3, select SIMPL Preferred. Otherwise, select SIMPL Standard.**

**Give Details** to questions answered "Yes" in Parts 2 and 3, above **(attach additional sheet, if necessary with Proposed Insured's signature).** You may also provide other additional information here.

_____

_____

**Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

Any insurance must first be approved for issuance by Liberty Bankers Life Insurance Company ("Liberty Bankers") on the basis of this Application. Coverage will begin when all three of the following have been met. (1) The policy has been issued, received, and accepted by the Proposed Owner. (2) Liberty Bankers has received the first full premium. (3) The Proposed Insured's health and other conditions are as described in this Application.

I must agree in writing to any amendment in the amount, classification, plan of insurance, or benefits. Otherwise, I authorize Liberty Bankers to correct any other errors and omissions as necessary. I understand my acceptance of any coverage issued on this Application means I agree with any correction. I understand the first premium is due on the first draft day shown on page one after my Application is approved by Liberty Bankers. If I have given any cash or written out a check with this Application, then I have received a Condition Receipt.

I authorize any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me and, if applicable my dependents, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the MIB, Inc. ("MIB") to disclose my health, medical information, and non-medical information to Liberty Bankers Insurance Company, or its reinsurers. My authorization includes 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).

I understand that Liberty Bankers underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information, except MIB 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, or its reinsurers, to make a brief report of my protected health information to the MIB, Inc.

This Authorization will be valid for 24 months from the date I sign below. If I die during the contestability period of my coverage, this Authorization will be valid for an additional 24 months from the date of my death. I direct my next of kin or the personal representative of my estate to legally enforce this Authorization after my death.

I know that I, or my authorized representative, may request a copy of this authorization. This authorization may be revoked by me or my authorized representative at any time except to the extent Liberty Bankers has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I do not sign this authorization or if I alter or revoke it, except as specified above, Liberty Bankers may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to Liberty Bankers at [P.O. Box 224 – Brownwood, TX 76804-0224, 1-888-525-4467, FAX 1-888-525-5002].

**I certify that I have reviewed the questions and responses contained on this application. I certify that my responses are true and complete to the best of my knowledge and belief. I certify that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.**

X_____ _____ _____
Signature of Proposed Insured | Date | City/State

X_____ _____ _____
Signature of Applicant/Owner (if other than Proposed Insured) | Date | City/ State

**********

| **Producer Statement:** | **YES** | **NO** |
|---|---|---|
| 1. Did you give the Applicant(s) a copy of the Privacy Notice and other disclosure information? | □ | □ |
| 2. Are you related to the Proposed Insured? | □ | □ |
| 3. Was this Application taken: [ □ in person? □ by tele-sales? □ by i-Pad? □ by mail or email? ] | | |
| 4. Do you know anything not disclosed which might affect the underwriting of this risk? | □ | □ |
| 5. Does the Proposed Insured have any existing life insurance policies or annuity contracts? | □ | □ |
| 6. Is replacement of existing insurance involved in this Application? | □ | □ |

**Note**: If either 5 or 6 is checked "yes" you must comply with the replacement requirements for the Proposed Owner's state.

X_____ _____ _____
Producer's Signature | Producer's Name | Producer Number

**For Use With Form Number ICC19-TAPP-LBL-0819**

# THIS PAGE TO BE LEFT WITH APPLICANT

**FAIR CREDIT REPORTING ACT PRE-NOTIFICATION FORM**. Thank you for considering Liberty Bankers Life Insurance Company ("Liberty Bankers") 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, 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, 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 FOR CASH OR CHECK RECEIVED WITH APPLICATION

**(**DO **NOT** COMPLETE FOR ACH OR BANK DRAFT FOR A FUTURE DATE**)**

INSURANCE BASED ON THE APPLICATION WILL TAKE EFFECT ONLY IF BOTH OF THESE CONDITIONS ARE MET:

1. On the effective date for coverage the Proposed Insured is insurable under Liberty Bankers' rules for the applied for plan, amount, and premium rate.

2. That the sum paid is equal to the full first premium.

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 medical requested by the Company.

The total amount of all Liberty Bankers coverage that may become effective prior to delivery of the policy to the Owner shall not exceed $25,000. This limit includes riders, inforce, and applied for coverage.

LIBERTY BANKERS LIFE INSURANCE COMPANY has received $ _____ for Applicant (name) _____

X_____ _____

Producer's Signature Date

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

*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 _____

**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: _____ Agent Number _____

Liberty Bankers Life
Insurance Company

*P.O. Box 224 Brownwood, Texas 76804 1(800) 604-8002*

**Delaware Replacement**

# Notice to Applicant Regarding Replacement of Life Insurance or Annuity

It is in your best interest to get all the facts before making a decision. Make sure you fully understand both the proposed new policy and your existing insurance. New policies may contain provisions which limit benefits during the initial period of the contract, in particular, the suicide and incontestable clauses.

To assist you in evaluating the proposed and the existing insurance, Delaware Insurance Regulation 30 requires that the insurer advising or recommending replacement:

Provide the consumer, not later than the date the policy or contract is delivered, a concise summary of the policy contract to be issued.

Allow a twenty-day period following the delivery of the policy during which time the consumer may surrender the new policy for a full refund.

Advise the present insurance company(ies) of the pending replacement.

This same regulation requires your present insurer to provide, on your request, a similar summary describing your present insurance. This information will be provided if you request it using the form below.

**INFORMATION ON PRESENT POLICIES**

| Company Name | Policy Number | Name of Insured | Summary Requested Mark Yes or No |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

(continue on reverse as required)

**IT IS SELDOM WISE TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT TO BE ACCEPTABLE.**

I have read this notice and received a copy of it.

Applicant's Signature _____ Date _____

Agent's Signature _____ Date _____

Agent's Name and Address (Printed) _____ Company Name _____