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.

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

3. Health Information

To the best of your knowledge and belief:

1. Has any Proposed Insured Child/Grandchild ever been diagnosed by a medical professional 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 been diagnosed or received treatment for AIDS, AIDS Related Complex or had a positive FDA-licensed test for antibodies to AIDS*?..... ☐Yes ☐No
   * *Information about AIDS or HIV status is limited to a positive diagnosis made by a member of the medical profession. HIV test results received at an anonymous counseling and testing site or results from a home test kit are not subject to disclosure. None of the application questions should be interpreted as asking about AIDS, unless the question specifically mentions AIDS.*
3. Has any Proposed Insured Child/Grandchild ever used or received treatment, advice or counseling from a medical professional 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.

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 (City)_____ (State)_____ this (Day)_____ of (Month)_____ , Year_____

Signature of Grandparent/Parent Guardian _____

Signature of Agent:_____ Agent Number:_____