

SERFF Tracking Number: LBLI-126364352 State: Arkansas
 Filing Company: Liberty Life Insurance Company State Tracking Number: 44102
 Company Tracking Number: DTA301UNLN(01-10)ET AL
 TOI: L04G Group Life - Term Sub-TOI: L04G.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium
 Product Name: Uniform Life Application
 Project Name/Number: /

Filing at a Glance

Company: Liberty Life Insurance Company

Product Name: Uniform Life Application

TOI: L04G Group Life - Term

SERFF Tr Num: LBLI-126364352

State: Arkansas

SERFF Status: Closed-Approved-Closed

State Tr Num: 44102

Sub-TOI: L04G.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium

Co Tr Num: DTA301UNLN(01-10)ET AL

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Julie Duncan, Dianne Harris

Disposition Date: 11/18/2009

Date Submitted: 11/13/2009

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed Simultaneously

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Trust

Filing Status Changed: 11/18/2009

Explanation for Other Group Market Type:

State Status Changed: 11/18/2009

Deemer Date:

Created By: Dianne Harris

Submitted By: Dianne Harris

Corresponding Filing Tracking Number:

Filing Description:

Form Number DTA301UNLN(01-10)

Liberty Life Insurance Company, NAIC Co. No. 61492, Group 0000, FEIN 44-0188050

The referenced form is being submitted for your review and approval. This is a new form and will not replace any forms currently on file with your department. This application form is to be used with policy form number L-338 et al, which was

SERFF Tracking Number:	LBLI-126364352	State:	Arkansas
Filing Company:	Liberty Life Insurance Company	State Tracking Number:	44102
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TOI:	L04G Group Life - Term	Sub-TOI:	L04G.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium
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approved by your department on 5-15-89 and recently updated for 2001 CSO on 4-30-08, and any term life products that are approved by your department in the future.

Form Number DTA301UNLN(01-10) is an application that will be used to market products in a paper environment through direct mail and statement solicitations. Please find attached a bracketed version completed in John Doe fashion. All bracketed sections are considered variable, and an Explanation of Brackets is enclosed to explain each variable section.

The form submitted is in final print and is subject to only minor modification in paper size and stock, formatting, ink, border, Company logo, and adaptation to computer printing.

To the best of my knowledge and belief, these forms comply with the statutory and regulatory requirements of your state. These forms contain no unusual or possible controversial items from normal company or industry standards. Please contact me if you need additional information. If you have any questions or need additional information, please contact me at 864-609-8350 or by email at Dianne.K.Harris@rbc.com.

Company and Contact

Filing Contact Information

Dianne Harris, Compliance Analyst	dianne.k.harris@rbc.com
2000 Wade Hampton Blvd	864-609-1198 [Phone]
Greenville, SC 29615	864-609-1039 [FAX]

Filing Company Information

Liberty Life Insurance Company	CoCode: 61492	State of Domicile: South Carolina
2000 Wade Hampton Blvd	Group Code:	Company Type:
Greenville, SC 29602	Group Name:	State ID Number:
(864) 609-4815 ext. [Phone]	FEIN Number: 44-0188050	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$20.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number: LBLI-126364352 State: Arkansas
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Fixed/Indeterminate Premium
Product Name: Uniform Life Application
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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty Life Insurance Company	\$20.00	11/13/2009	32027479

SERFF Tracking Number: LBLI-126364352 State: Arkansas
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TOI: L04G Group Life - Term Sub-TOI: L04G.314 Decreasing - Joint (First to Die) -
Fixed/Indeterminate Premium
Product Name: Uniform Life Application
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	11/18/2009	11/18/2009

SERFF Tracking Number: *LBLI-126364352* State: *Arkansas*
 Filing Company: *Liberty Life Insurance Company* State Tracking Number: *44102*
 Company Tracking Number: *DTA301UNLN(01-10)ETAL*
 TOI: *L04G Group Life - Term* Sub-TOI: *L04G.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium*

Product Name: *Uniform Life Application*
 Project Name/Number: */*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Explanation of Variability		Yes
Supporting Document	Readability		Yes
Form	Decreasing Term Life Insurance Application		Yes

SERFF Tracking Number: LBLI-126364352 State: Arkansas
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 TOI: L04G Group Life - Term Sub-TOI: L04G.314 Decreasing - Joint (First to Die) -
 Fixed/Indeterminate Premium
 Product Name: Uniform Life Application
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Form Schedule

Lead Form Number: DTA301UNLN(01-10)et al

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	DTA301UNLN(01-10)	UN	Application/Decreasing Term Life Insurance Enrollment Form	Initial		51.000	DTA301UNLN(01-10)-doe-bracketed.pdf DTA301UNLN(01-10).pdf

LIFE INSURANCE APPLICATION

Liberty Life Insurance Company

[PO Box 789 Greenville, SC 29602-0789]

This application is for decreasing term life insurance in the initial amount of: **\$299,999**

1

If you desire partial coverage, enter amount here: \$150,000
(Minimum \$15,000)

CIDN:

Questions? Contact us at: 1.800.813.4412

Premiums are based on the age of older insured. To qualify for non-tobacco rates both applicants must not use tobacco.

Age	Non-Tobacco Rates		Tobacco Rates	
	Single	Joint	Single	Joint
Under 30	\$999.99	\$999.99	\$999.99	\$999.99
30-34	\$999.99	\$999.99	\$999.99	\$999.99
35-39	\$999.99	\$999.99	\$999.99	\$999.99
40-44	\$999.99	\$999.99	\$999.99	\$999.99
45-49	\$999.99	\$999.99	\$999.99	\$999.99
50-54	\$999.99	\$999.99	\$999.99	\$999.99
55-59	\$999.99	\$999.99	\$999.99	\$999.99
60-64	\$999.99	\$999.99	\$999.99	\$999.99

Name **John Q. Doe**
Street 1 **123 Any Street**
Street 2
City, State Zip **Anytown, AS 12345**
[BC123123123123]

2

3

3

4

[APPLICANT] (Please Print)

First John		Middle Q.		Last Name Doe	
Date of Birth 5/20/1968	State of Birth AS	Occupation Teacher	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status M	
Social Security # xxx-xx-xxxx		Height 6' 0"	Weight 160 lbs.		
Home Telephone # 123-456-7890	Business Telephone # 987-654-3210	Cell Phone # 444-555-7878			
Email Address jdoe@aol.com	Driver's License # DL1234567		State AS		
Applicant's Beneficiary Jane S. Doe		Relationship Wife			

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6a

[Beneficiary]: **Jane S. Doe**

Mail ID: 9999 DM9 9999



SECOND APPLICANT (Please Print)

First		Middle		Last Name	
Date of Birth	State of Birth	Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	
Social Security #		Height		Weight	
Home Telephone #	Business Telephone #	Cell Phone #			
Email Address		Driver's License # State			
Second Applicant's Beneficiary			Relationship		

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- In the past 12 months, have you used any form of tobacco or nicotine products?
- In the past 5 years, have you received any treatment, medical advice, or consultation for; been diagnosed with; or required follow-up for:
 - any disease or disorder of the heart, coronary arteries, aorta, or peripheral arteries; stroke or TIA (transient ischemic attack); diabetes, borderline diabetes, elevated blood sugar or any other disease or disorder of the pancreas; tumor or cancer (other than basal cell or squamous cell carcinoma of the skin); chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, or any other chronic lung disease; or
 - chronic renal (kidney) insufficiency or failure or any other chronic disease or disorder of the kidney; hepatitis or any other chronic disease or disorder of the liver; ulcerative colitis or Crohn's disease; any chronic blood disease or disorder; rheumatoid arthritis or any other chronic disease or disorder of the muscles, joints, connective tissues, or bones; or
 - alcohol or drug use or abuse; current use of 2 or more prescribed pain medications; major depression; bipolar disorder; schizophrenia or any other chronic mental disorder; or any chronic disease or disorder of the brain or nerves; seizures, multiple sclerosis, paralysis, or any form of dementia (including Alzheimer's disease)?
- Have you been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or have you tested positive for HIV (Human Immunodeficiency Virus)?

FIRST APPLICANT		SECOND APPLICANT	
YES	NO	YES	NO
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7

If you answered "yes" to either questions 2 or 3, please circle the condition and provide details on the back of the application in the space provided. Include name and address of attending physician.

The Applicant(s) represent(s) that the following are the complete details to "Yes" answers in Questions 2 or 3: Attach a separate sheet if more space is needed.

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[Payment Authorization – [I/we] authorize my/our lending institution to collect the premium along with [my/our] mortgage payment for the amount of insurance as indicated. If [I/we] have authorized my lending institution to automatically/electronically debit from my account, [I/we] hereby request this insurance premium to be added to this authorization. [I/we] authorize the information contained on this form and customer identification number to be provided to the Company and its Administrators which are non-affiliates of [my/our] **[Financial Institution]** to activate coverage. This authority is to remain in effect until [I/we] cancel it in writing and until the Company **[or my/our financial institution]** actually receives such notice.]

Acknowledgement - By signing below, each person applying for coverage represents and agrees to the following. The statements and answers made in this application are true and complete and are made to obtain the insurance applied for. It is understood that insurance will take effect only if Liberty Life Insurance Company (the "Company") accepts this application and issues a policy/certificate and if, on the date of issue, (1) the first premium has been paid, (2) you are alive, (3) all conditions used to determine your insurability remain as stated in the application, and (4) the mortgage loan to which the proposed insurance applies is in effect. No one except the Company's Home Office officers can make, change or discharge any insurance contract, or bind the Company by making any promises about any policy benefits applied for. [You acknowledge you have been provided and understand the Consumer Information, Disclosures, and Notices that follow or accompany this application.]

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Authorization to Obtain and Disclose Information - I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other health care provider, pharmacy or pharmacy benefit manager, insurance company or reinsurer, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer, mortgage loan broker, financial institution, or other organization, institution or person to give to the Company's insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers the following information about me: information on my mortgage loan; past and present physical, mental, drug and/or alcohol conditions; other insurance coverage; prescribed drugs; employment; avocations; general reputation; and other personal characteristics. I understand that the Company will collect this information for the purpose of determining eligibility for insurance. I further understand and agree that the Company may disclose all or some of my information to the MIB and the Company's insurance administrators, reinsurers, agents, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months and a photographic copy is as valid as the original. I understand that I am entitled to receive a copy of this authorization upon request and that I have the right to revoke this authorization by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation might cause the Company to reject this application.

Certain state insurance departments require that we advise you of the following statements:

For Arkansas and Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

For Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For Louisiana and New Mexico Residents: NOTICE: Any 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 is guilty of a crime and may be subject to civil fines and criminal penalties.

For Virginia Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

[Insurance products are not FDIC insured; not insured by any federal government agency; are not deposits in, obligations of, guaranteed or underwritten by the bank/affiliate; and are not conditions of any bank service.]

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Are you planning to replace, discontinue or change an existing policy or contract? Yes No

If "yes," give company name and benefit amount: _____

FIRST APPLICANT SIGNATURE	DATE
X <i>John Q. Doe</i>	1/1/2010

SECOND APPLICANT SIGNATURE	DATE
X	/ /

7

LIFE INSURANCE APPLICATION

Liberty Life Insurance Company

PO Box 789 Greenville, SC 29602-0789

This application is for decreasing term life insurance
in the initial amount of: **\$xxx,xxx**

Questions? Contact us at: 1.800.813.4412

If you desire partial coverage, enter amount here: _____
(Minimum \$15,000)

CIDN:

Premiums are based on the age of older insured. To qualify for non-tobacco rates both applicants must not use tobacco.

Age	Non-Tobacco Rates		Tobacco Rates	
	Single	Joint	Single	Joint
Under 30	\$999.99	\$999.99	\$999.99	\$999.99
30-34	\$999.99	\$999.99	\$999.99	\$999.99
35-39	\$999.99	\$999.99	\$999.99	\$999.99
40-44	\$999.99	\$999.99	\$999.99	\$999.99
45-49	\$999.99	\$999.99	\$999.99	\$999.99
50-54	\$999.99	\$999.99	\$999.99	\$999.99
55-59	\$999.99	\$999.99	\$999.99	\$999.99
60-64	\$999.99	\$999.99	\$999.99	\$999.99

Name
Street 1
Street 2
City, State Zip

Beneficiary:

Mail ID:



APPLICANT (Please Print)

First		Middle		Last Name	
Date of Birth	State of Birth	Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	
Social Security #			Height	Weight	
Home Telephone #	Business Telephone #	Cell Phone #			
Email Address		Driver's License #	State		
Applicant's Beneficiary			Relationship		

SECOND APPLICANT (Please Print)

First		Middle		Last Name	
Date of Birth	State of Birth	Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	
Social Security #			Height	Weight	
Home Telephone #	Business Telephone #	Cell Phone #			
Email Address		Driver's License #	State		
Second Applicant's Beneficiary			Relationship		

- In the past 12 months, have you used any form of tobacco or nicotine products?
- In the past 5 years, have you received any treatment, medical advice, or consultation for; been diagnosed with; or required follow-up for:
 - any disease or disorder of the heart, coronary arteries, aorta, or peripheral arteries; stroke or TIA (transient ischemic attack); diabetes, borderline diabetes, elevated blood sugar or any other disease or disorder of the pancreas; tumor or cancer (other than basal cell or squamous cell carcinoma of the skin); chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, or any other chronic lung disease; or
 - chronic renal (kidney) insufficiency or failure or any other chronic disease or disorder of the kidney; hepatitis or any other chronic disease or disorder of the liver; ulcerative colitis or Crohn's disease; any chronic blood disease or disorder; rheumatoid arthritis or any other chronic disease or disorder of the muscles, joints, connective tissues, or bones; or
 - alcohol or drug use or abuse; current use of 2 or more prescribed pain medications; major depression; bipolar disorder; schizophrenia or any other chronic mental disorder; or any chronic disease or disorder of the brain or nerves; seizures, multiple sclerosis, paralysis, or any form of dementia (including Alzheimer's disease)?
- Have you been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or have you tested positive for HIV (Human Immunodeficiency Virus)?

<u>FIRST APPLICANT</u>		<u>SECOND APPLICANT</u>	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "yes" to either questions 2 or 3, please circle the condition and provide details on the back of the application in the space provided. Include name and address of attending physician.

The Applicant(s) represent(s) that the following are the complete details to "Yes" answers in Questions 2 or 3: Attach a separate sheet if more space is needed.

Payment Authorization – [I/we] authorize my/our lending institution to collect the premium along with [my/our] mortgage payment for the amount of insurance as indicated. If [I/we] have authorized my lending institution to automatically/electronically debit from my account, [I/we] hereby request this insurance premium to be added to this authorization. [I/we] authorize the information contained on this form and customer identification number to be provided to the Company and its Administrators which are non-affiliates of [my/our] **[Financial Institution]** to activate coverage. This authority is to remain in effect until [I/we] cancel it in writing and until the Company **[or my/our financial institution]** actually receives such notice.

Acknowledgement - By signing below, each person applying for coverage represents and agrees to the following. The statements and answers made in this application are true and complete and are made to obtain the insurance applied for. It is understood that insurance will take effect only if Liberty Life Insurance Company (the "Company") accepts this application and issues a policy/certificate and if, on the date of issue, (1) the first premium has been paid, (2) you are alive, (3) all conditions used to determine your insurability remain as stated in the application, and (4) the mortgage loan to which the proposed insurance applies is in effect. No one except the Company's Home Office officers can make, change or discharge any insurance contract, or bind the Company by making any promises about any policy benefits applied for. You acknowledge you have been provided and understand the Consumer Information, Disclosures, and Notices that follow or accompany this application.

Authorization to Obtain and Disclose Information - I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other health care provider, pharmacy or pharmacy benefit manager, insurance company or reinsurer, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer, mortgage loan broker, financial institution, or other organization, institution or person to give to the Company's insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers the following information about me: information on my mortgage loan; past and present physical, mental, drug and/or alcohol conditions; other insurance coverage; prescribed drugs; employment; avocations; general reputation; and other personal characteristics. I understand that the Company will collect this information for the purpose of determining eligibility for insurance. I further understand and agree that the Company may disclose all or some of my information to the MIB and the Company's insurance administrators, reinsurers, agents, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months and a photographic copy is as valid as the original. I understand that I am entitled to receive a copy of this authorization upon request and that I have the right to revoke this authorization by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation might cause the Company to reject this application.

Certain state insurance departments require that we advise you of the following statements:

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For Virginia Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Are you planning to replace, discontinue or change an existing policy or contract? Yes No

If "yes," give company name and benefit amount: _____

FIRST APPLICANT SIGNATURE	DATE
X	/ /

SECOND APPLICANT SIGNATURE	DATE
X	/ /

SERFF Tracking Number: LBLI-126364352 State: Arkansas
 Filing Company: Liberty Life Insurance Company State Tracking Number: 44102
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 TOI: L04G Group Life - Term Sub-TOI: L04G.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium
 Product Name: Uniform Life Application
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: Readability non-officer DTA301UNLN(01-10) non officer.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: Application attached under form schedule		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Explanation of Variability		
Comments:		
Attachment: DTA301UNLN explanation of brackets.pdf		

	Item Status:	Status Date:
Satisfied - Item: Readability		
Comments:		
Attachment: Readability non-officer DTA301UNLN(01-10) non officer.pdf		

READABILITY COMPLIANCE CERTIFICATION

1. Insurer: Liberty Life Insurance Company
PO Box 789
Greenville, South Carolina 29602-0789
2. Certification: I hereby certify that the forms listed below produce Flesch reading ease scores which meet the minimum score required in your state.

In addition, I certify that the forms, except for schedules and tables, are printed in 10 point type, one point leaded. The words and terminology exempted are: (a) all words and terms defined in the forms, (b) all captions and subcaptions, (c) all tables and schedules, and (d) all medical terms. All exempted items are permitted in your state.

READABILITY SCORE

<u>Name of Form</u>	<u>Form Number</u>	<u>Flesch Score</u>
Application	DTA301UNLN (01-10)	51

11-16-09
Date



Dianne Harris
Compliance Specialist I Policy Forms/Compliance

Life Insurance Application
 Form Number DTA301UNLN(01-10) et al
 Explanation of Brackets
 Page 1

- **General Purpose Information** such as Company Address is bracketed to reflect variability. Items such as the barcode, Mail ID and Plan ID may vary in location and content depending on the product offering and vendor specifications.

(1) This offer section will vary depending upon the amount of insurance being offered. Partial coverage may or may not be offered.

Decreasing Term Life:

Offer line This application is for decreasing term life insurance in the initial amount of:
\$999,999 (note: if coverage is for mortgage term life, the amount is equal to the remaining mortgage loan balance at time of solicitation)

[If you desire partial coverage, enter amount here: _____]
 (minimum \$15,000)

Customer Number: XXXXXXXXXXXXXXX

- (2) The name and address may or may not be pre-printed. If it is not pre-printed, space will be provided for the applicant to write in his or her name and address.
- (3) This offer/rate section may appear to the right of the address area or below the address area as shown below.

Note: the "joint" sections may or may not appear, depending upon whether or not joint coverage is being offered.

STANDARD MONTHLY PREMIUM Current age [- Older Applicant's Current Age, if joint coverage. To qualify for non-tobacco joint rates, both applicants must be non-tobacco users.]

AGE		Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Non-Tobacco Rates	Single	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99
	Joint	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99
Jobacco Rates	Single	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99
	Joint	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99

-OR-

Standard Monthly Premium (Current Age[- Older applicant's Current Age, if joint coverage])

Age	18-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69		
Single (1 life)	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99		
Joint (2 lives)	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99	\$99.99		

- (4) This section may read "Applicant" or "First Applicant", depending upon the product being offered and also whether or not joint/spouse coverage is being offered.
- (5) Changes within this section are limited to the following: One, two, or all three telephone number sections may appear. Email Address may not appear. The driver's license and social security number fields may or may not appear. If we need to obtain this information for underwriting purposes (e.g. match criteria for MIB searches), it will appear on the form. Otherwise, it will not. In addition to the items described above, State of Birth will not appear in states that do not allow this field.
- (6) The "Beneficiary" and "Relationship" fields may or may not appear, depending on whether or not the product being offered is tied to a mortgage. If the offer is for mortgage decreasing term life, it will not appear, as the beneficiary is pre-printed in section (6a) where allowed by state law. If state law does not allow beneficiary pre-designation, it will appear to provide a place for the applicant to name a beneficiary.
- (7) The "Second Applicant" section may or may not appear, depending upon the particular campaign. In addition, "Second Applicant" in the heading of this section may also read "Joint Applicant" or "Spouse", depending upon the terminology used in the applicable policy or certificate.
- (8) This section will vary depending on the billing and collection method(s) offered, mortgage escrow payment, direct bill payment, credit card payment or bank draft options. Sample wording for these payment types follows:

Mortgage Payment Offered:

I/we authorize my/our lending institution to collect the premium along with my/our mortgage payment for the amount of insurance as indicated. If I have authorized my lending institution to automatically/electronically debit from my account, I hereby request this insurance premium to be added to this authorization. I/we authorize the information contained on this form and customer identification number to be provided to the Company and its Administrators which are non-affiliates of my/our [Financial Institution] to activate coverage. This authority is to remain in effect until I cancel it in writing and until the Company [or my/our financial institution] actually receives such notice.

[The actual name of the Mortgage Company may be shown in lieu of "Financial Institution". Additionally "or Financial Institution" may appear at the end of the last sentence if so required by the Financial Institution.]

Direct Bill Payment Offered:

Direct Bill (check one): Monthly Quarterly Semi-Annually Annually

Credit Card Payment Offered:

Charge to my credit card: [Visa Master Card American Express Discover]

I authorize the premium to be processed and remitted to Liberty Life Insurance Company through my credit card account as referenced herein. This authority is to remain in effect until I cancel it in writing and until the Company or my credit card company actually receives such notice.

Credit Card Number: _____ Expiration Date: _____ / _____

Name as it appears on the Credit Card: _____

Payment Frequency: Monthly Quarterly Semi-Annually Annually

Bank Draft (Checking Account) Payment Offered:

I request and authorize my financial institution to pay and charge to my account electronic debits on my account, by and payable to Liberty Life Insurance Company, provided there are sufficient funds in my account at the time the debit is made. I understand and agree that the financial institution will not be liable for any payment that may not be honored, intentionally or inadvertently, even if such dishonor results in forfeiture of insurance. This authority is to remain in effect until revoked by me in writing, and until the financial institution actually receives such notice.

I understand that my premium due date will not change and the electronic debit drawn on my account will occur no earlier than the due date and no later than two business days after the due date.

Full Name(s) on Account: _____

Bank Name: _____

Bank Routing Number: _____ Checking Savings Account Number: _____

(9) This sentence may be amended to address the actual location of the consumer information, disclosures, and notices. One alternative statement may be, 'By Signing this application, you acknowledge you have been provided and understand the information contained on the accompanying page titled "Consumer Information, Disclosures, and Notices".'

(10) The FDIC disclosure may or may not appear on the form, depending on the particular campaign. If the product is not being offered through a financial institution, it will not appear. However, it will appear if the organization is a financial institution, in accordance with the GLB Act.

READABILITY COMPLIANCE CERTIFICATION

1. Insurer: Liberty Life Insurance Company
PO Box 789
Greenville, South Carolina 29602-0789
2. Certification: I hereby certify that the forms listed below produce Flesch reading ease scores which meet the minimum score required in your state.

In addition, I certify that the forms, except for schedules and tables, are printed in 10 point type, one point leaded. The words and terminology exempted are: (a) all words and terms defined in the forms, (b) all captions and subcaptions, (c) all tables and schedules, and (d) all medical terms. All exempted items are permitted in your state.

READABILITY SCORE

<u>Name of Form</u>	<u>Form Number</u>	<u>Flesch Score</u>
Application	DTA301UNLN (01-10)	51

11-16-09
Date



Dianne Harris
Compliance Specialist I Policy Forms/Compliance