

<i>SERFF Tracking Number:</i>	<i>LBLI-126003369</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Liberty Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41418</i>
<i>Company Tracking Number:</i>	<i>MLDT(03-09)</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>RBC Mortgage Decreasing Term</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Liberty Life Insurance Company	SERFF Tr Num: LBLI-126003369	State: ArkansasLH
Product Name: RBC Mortgage Decreasing Term		
TOI: L04I Individual Life - Term	SERFF Status: Closed	State Tr Num: 41418
Sub-TOI: L04I.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium	Co Tr Num: MLDT(03-09)	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Julie Duncan, Holly Carver	Disposition Date: 02/04/2009
	Date Submitted: 01/30/2009	Disposition Status: Approved
Implementation Date Requested: 03/31/2009		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: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/04/2009	
State Status Changed: 02/04/2009	Deemer Date:
Corresponding Filing Tracking Number:	
Filing Description:	

The referenced forms are being submitted for your review and approval. These are new forms and will not replace any forms currently on file with your department. The decreasing term life policy form is similar to a form previously approved by your department on 3-18-04, and recently updated for 2001 CSO on 7-03-08. The primary differences include a change from blended to sex-distinct rates, the consideration of tobacco use, and accompanying provisions in

SERFF Tracking Number: LBLI-126003369 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 41418
Company Tracking Number: MLDT(03-09)
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Fixed/Indeterminate Premium
Product Name: RBC Mortgage Decreasing Term
Project Name/Number: /

the contract to address these items. These forms are being provided to you in final printed form.

Form Number MLDT(03-09) is a decreasing term life insurance policy which will be used for mortgage protection insurance. The premiums for this coverage will remain level until the end of the 10th policy year. Please see the Actuarial Memorandum for details. The product will be marketed through various avenues.

Form Number RBCMPG(01-09)AR is the application to be used with this product and will be marketed through licensed brokers, including mortgage brokers. We may also market this product through internet sales and other licensed agent sales. Please find attached a version completed in John Doe fashion, as well as a blank, bracketed version. All bracketed sections are considered variable, and an Explanation of Brackets is enclosed to explain each variable section. The applicants' and/or agents' signatures may be captured traditionally with a wet signature, electronically or via voice signature.

Form Number RBCMPD(01-09)AR is the application to be used with this product in a direct mail or statement insert solicitation method. A John Doe version, as well as a blank, bracketed version of this application is included, along with an Explanation of Brackets explaining each variable section.

The product will not be illustrated.

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

Please see the Supporting Documentation Tab and the Form Schedule for other necessary filing information. 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.

Company and Contact

Filing Contact Information

Holly Carver, Compliance Specialist II

holly.carver@rbc.com

SERFF Tracking Number: LBLI-126003369 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 41418
Company Tracking Number: MLDT(03-09)
TOI: L04I Individual Life - Term Sub-TOI: L04I.314 Decreasing - Joint (First to Die) -
Fixed/Indeterminate Premium

Product Name: RBC Mortgage Decreasing Term
Project Name/Number: /

2000 Wade Hampton Blvd (864) 609-4871 [Phone]
Greenville, SC 29615 (864) 609-3484[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

SERFF Tracking Number: LBLI-126003369 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 41418
Company Tracking Number: MLDT(03-09)
TOI: L04I Individual Life - Term Sub-TOI: L04I.314 Decreasing - Joint (First to Die) -
Fixed/Indeterminate Premium
Product Name: RBC Mortgage Decreasing Term
Project Name/Number: /

Filing Fees

Fee Required? Yes
Fee Amount: \$90.00
Retaliatory? No
Fee Explanation: \$50.00 x 1 policy
\$20.00 x 2 applications
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty Life Insurance Company	\$90.00	01/30/2009	25395662

SERFF Tracking Number: LBLI-126003369 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 41418
Company Tracking Number: MLDT(03-09)
TOI: L04I Individual Life - Term Sub-TOI: L04I.314 Decreasing - Joint (First to Die) -
Fixed/Indeterminate Premium
Product Name: RBC Mortgage Decreasing Term
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	02/04/2009	02/04/2009

SERFF Tracking Number: *LBLI-126003369* State: *Arkansas*
Filing Company: *Liberty Life Insurance Company* State Tracking Number: *41418*
Company Tracking Number: *MLDT(03-09)*
TOI: *L04I Individual Life - Term* Sub-TOI: *L04I.314 Decreasing - Joint (First to Die) -
Fixed/Indeterminate Premium*
Product Name: *RBC Mortgage Decreasing Term*
Project Name/Number: */*

Disposition

Disposition Date: 02/04/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *LBLI-126003369* State: *Arkansas*
 Filing Company: *Liberty Life Insurance Company* State Tracking Number: *41418*
 Company Tracking Number: *MLDT(03-09)*
 TOI: *L04I Individual Life - Term* Sub-TOI: *L04I.314 Decreasing - Joint (First to Die) - Fixed/Indeterminate Premium*

Product Name: *RBC Mortgage Decreasing Term*
 Project Name/Number: */*

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Expl of Brackets - RBCMPG		Yes
Supporting Document	Expl of Brackets - RBCMPD		Yes
Supporting Document	MDLT- Statement of Policy Cost and Benefit		Yes
Form	RBC Mortgage Decreasing Term Life		Yes
Form	Application		Yes
Form	Application		Yes

SERFF Tracking Number: LBLI-126003369 State: Arkansas
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Form Schedule

Lead Form Number: MLDT(03-09)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	MLDT(03-09)	Policy/Cont	RBC Mortgage ract/Fratern Decreasing Term Life al Certificate	Initial		57	MLDT(03-09).pdf
	RBCMPG(01-09)AR	Application/Enrollment Form	Application	Initial		57	RBCMPG(01-09)AR-bracket.pdf RBCMPG(01-09)AR-doe.pdf
	RBCMPD(01-09)AR	Application/Enrollment Form	Application	Initial		50	RBCMPD(01-09)AR-bracket.pdf RBCMPD(01-09)AR-doe.pdf

Name of Insured(s):	John Q. Doe	Term Period:	30 Years
Date of Issue:	01/15/2009	Expiration Date:	01/15/2039
Initial Death Benefit:	\$100,000		
Policy Number:	123456789		

We will pay the Death Benefit promptly when we receive, at our Administrative Office, due proof that the Insured died prior to the Expiration Date and while the Policy was in Full Force. Death Benefits will be paid to the Beneficiary. Payment is subject to all provisions of this Policy.

Consideration - This Policy is issued based on the application and the payment of the premium on or before policy delivery.

31-DAY RIGHT TO EXAMINE POLICY
This Policy may be cancelled within 31 days after receipt by returning it to us or to our agent. If returned, we will refund all premiums paid, and this Policy will be void from the Date of Issue.

We have issued this Policy at our Home Office as of the Date of Issue.

This Policy is a legal contract between the Owner and Us.

PLEASE READ THIS POLICY CAREFULLY!



Secretary



President

This is a Policy for Decreasing Term Life Insurance.
Premiums for Single or Joint Coverage
Premiums are level until the end of the 10th Policy Year.
After the 10th Policy Year premiums may increase (subject to
Guaranteed Maximum Premium) annually on the Policy Anniversary.
Payable at death, or First Death, if Joint Coverage.
This is Nonparticipating and Nonconvertible Coverage.

A GUIDE TO POLICY PROVISIONS

Provision	Page No.
Definitions.....	2
Policy Schedule.....	3
Benefit Provisions	4
Death Benefit Payable	
Amount of Death Benefit	
Amount of Death Benefit for Refinanced Loans	
Premium Provisions	4
Amount and Frequency	
Grace Period	
Reinstatement	
Refund of Unearned Premiums	
General Provisions	5
Assignment	
Beneficiary	
Change of Beneficiary	
Entire Contract	
Effective Date	
Expiration Date	
Interest Before Settlement	
Incontestable	
Premium Class	
Change in Premium Class	
Misstatement of Age or sex	
Nonconvertible	
Nonparticipating	
Owner	
Change of Owner	
Proof of Death	
Suicide	
Conformity with Law	
Termination Provisions.....	6
Termination of Coverage	

DEFINITIONS

Administrative Office means the office at PO Box 19084, Greenville, South Carolina, 29602-9084 or a new address of which we notify You. All correspondence regarding this Policy should be sent to our Administrative Office.

Age means Your age last birthday or the age of the older Insured if joint coverage.

Attained Age on any date means Your Age at the Date of Issue plus the number of Policy Years and completed Policy months from the Date of Issue to that date.

The **Beneficiary** is named on Page 3 (Policy Schedule) until changed by the Owner, in accordance with the Change of Beneficiary provision.

Date of Issue means the date shown on Page 3. Policy Years, Policy Anniversaries, premium due dates, Term Period and the Expiration Date are measured from this date.

Death Benefit is the amount payable when You die. The Initial Death Benefit, shown on Page 3, is the Death Benefit as of the Date of Issue.

Eligible Borrower is a person age 60 or under who becomes indebted to a lender under an Eligible Loan. Only Eligible borrowers may apply for this insurance. Two borrowers under the same Eligible Loan may apply for joint coverage if the older borrower is age 60 or under. A borrower will not be eligible if the insurance is intended to cover the indebtedness of a business.

Eligible Loan means an indebtedness: (a) repayable within not more than 30 years; and (b) secured by a first mortgage lien or deed of trust on the real property referenced in the application for this Policy. The loan referenced in the application must be an Eligible Loan for this Policy to be valid.

Expiration Date is the date Your insurance is scheduled to terminate under the terms of this Policy. The Expiration Date is shown on Page 3.

Full Force means that no premium is more than 31 days past due and the Policy has not otherwise terminated.

Home Office means our office at 2000 Wade Hampton Boulevard, Greenville, South Carolina 29615 (Mailing address: PO Box 19099, Greenville, South Carolina 29602-9099).

The **Insured, also referred to as You and Your**, is the Eligible Borrower (or borrowers, if joint coverage) who becomes insured under this Policy. Insured refers to one person insured as a Single Insured or to two persons insured as Joint Insureds.

Owner is the Insured unless changed in accordance with the Change of Owner provision. In case of joint coverage, the Insured designated as the First Applicant on the application shall be the Owner unless changed in accordance with the Change of Owner provision.

Policy Anniversary means the same month and day in each succeeding year as the Date of Issue.

Policy Year is the period of time from the Date of Issue to the First Policy Anniversary, and each period of time from Policy Anniversary to Policy Anniversary thereafter.

Refinance means the discharge of an Eligible Loan with the proceeds of a new Eligible Loan. The new loan in this instance may be referred to as a **Refinanced Loan**.

Term Period means the period (shown on Page 3) from the Date of Issue to the Expiration Date.

We, our, and us refer to Liberty Life Insurance Company.

Written Notice means a request signed by the Owner on a form: (a) which we furnish; or (b) other than ours which we accept.

You and Your refer to the Insured(s).

BENEFIT PROVISIONS

Death Benefit Payable: We will pay the Death Benefit to the Beneficiary as soon as possible after receiving at our Administrative Office due proof of Your death and other information necessary to process the claim.

In case of joint coverage, the proceeds will be paid at the death of the first Joint Insured as explained under Amount of Death Benefit. In the event that we receive proof that Joint Insureds died simultaneously, we will pay the proceeds as if the older Insured died first. Only one Death Benefit will be paid.

Amount of Death Benefit: The Initial Death Benefit amount is shown on the Policy Schedule. The Amount of the Death Benefit provided by this Policy will be calculated by determining from Your application the ratio that the Initial Death Benefit bears to the initial loan balance. This ratio is then applied to the unpaid Eligible Loan balance on the date of Your death, or in the case of joint coverage, the date of the first Insured's death. For purposes of this Policy, the unpaid Eligible Loan balance does not include defaults in scheduled payments of either interest or principal, any penalties or late charges, real estate taxes or unpaid insurance premiums. The total amount payable will never exceed the lesser of the unpaid Eligible Loan balance or the initial amount of insurance. This applies to loans which have not been Refinanced. For a description of the amount of Death Benefit for Refinanced Loans, see Amount of Death Benefit for Refinanced Loans.

Amount of Death Benefit for Refinanced Loans: If Your Eligible Loan is Refinanced and Your Attained Age is 60 or under, You may apply for more coverage if the loan amount or loan term is increased above the then-current amount or remaining term. If Your application is approved, a new Policy will be issued. Premium rates will be based on Your age (or the older Insured's Age, if joint coverage) at the time of issue of the new Policy.

If Your Eligible Loan is Refinanced and You do not reapply for coverage, the Term Period and premiums for this Policy will remain the same. However, the Amount of Death Benefit on the Refinanced Loan will be calculated according to an amortization schedule using the interest rate and loan term referenced on the application for this Policy. Because Your coverage remains the same in all other aspects, the Amount of Death Benefit may be substantially less than the loan balance under the Refinanced Loan.

PREMIUM PROVISIONS

Amount and Frequency: The premiums payable for this Policy are specified on Page 3. After the first 10 Policy Years, we may change the premium annually. The Guaranteed Maximum Premium is shown on Page 3.

The first premium is due on the Date of Issue; after that, each premium is due and payable at the end of the period covered by the prior premium. Premiums are payable to our Administrative Office.

Subject to our consent, premiums may be paid as follows:

- (a) once a year (annually);
- (b) twice a year (semiannually);
- (c) four times a year (quarterly); or
- (d) twelve times a year (monthly).

Grace Period: A Grace Period of 31 days from the due date is allowed for the payment of each premium, except the first one. This Policy remains in Full Force during the Grace Period. If a premium is not paid by the end of the Grace Period, the Policy will lapse and be of no further value. If Your death occurs during a Grace Period, we will deduct from the Death Benefit that part of the unpaid premium from the due date to the date of Your death.

Reinstatement: This Policy may be put back in Full Force within three years after the date of lapse provided none of the conditions under the Termination provision of this Policy, except for termination for failure to pay premiums, has occurred.

To reinstate this Policy, we will require the following to be provided to us:

- (a) evidence of insurability satisfactory to us for all persons to be insured under the reinstated Policy;
- (b) payment of all past due premiums; and
- (c) payment of interest on each premium from its due date at six percent, compounded yearly.

Reinstatement will take effect when approved by us at our Administrative Office provided You are alive and all conditions used to determine Your insurability remain as stated in the reinstatement application.

We may not contest the reinstated Policy for material misstatements in the reinstatement application after the reinstated Policy has been in force during the lifetime of the Insured for two years from the date of reinstatement.

Refund of Unearned Premiums: If Your coverage terminates before the Expiration Date of the Policy, we will refund or credit any unearned premium. By unearned premium, we mean the part of any premium paid for a period beyond the Policy month of termination of coverage or of Your death. No refund or credit will be made if the unearned amount is less than \$5.

GENERAL PROVISIONS

Assignment: This Policy may not be assigned.

Beneficiary: The Beneficiary for this Policy is as shown in the Policy Schedule, unless changed in accordance with the Change of Beneficiary Provision.

Change of Beneficiary: The Owner may change the Beneficiary while You are alive by sending a Written Notice to our Administrative Office. Once we record a change, it will take effect as of the date of the Written Notice. A change will not apply to any action taken or payment made before we receive the Written Notice.

Entire Contract: This Policy and the application, a copy of which is attached, form the entire contract between us and the Owner. All statements made by You and for You, in the absence of fraud, will be considered representations and not warranties. No statement will be used to contest this Policy or in defense of a claim unless endorsed on or attached to this Policy. Only our President, a Vice President, the Secretary or an Assistant Secretary may change, modify or waive the provisions of this Policy and then only in writing.

Effective Date: The Policy will take effect as of the Date of Issue if on that date:

- (a) the first premium has been paid;
- (b) You are alive;
- (c) all conditions used to determine Your insurability remain as stated in the application; and
- (d) the Eligible Loan referenced on the application is in effect.

Otherwise, our only liability is to return all premiums paid for this Policy.

Expiration Date: The scheduled date of termination, or the Expiration Date, is shown on Page 3. In no event will coverage continue beyond the Policy Anniversary following Your age 70 (or the joint Insured's age 70, if joint coverage).

Interest Before Settlement: Interest will be added to benefits:

- (a) which are not paid within 30 days after receipt of due proof of death or the time provided by law;
- (b) from the date payable to the date benefits are paid for up to one year or the time required by law; and
- (c) at an annual rate determined by us, but not less than required by law.

Incontestable: We may not contest this Policy after it has been in force during the lifetime of the Insured for two years from the Date of Issue, except as otherwise provided in the Reinstatement provision.

Premium Class: Classification of the Insured as shown on Page 3 and is based on the plan applied for and the outcome of our underwriting of the Insured.

Change in Premium Class: You may request a change in Premium Class (from Tobacco to Non-Tobacco) if You are eligible. We must receive evidence satisfactory to us for such change. Any such change is subject to our approval.

Misstatement of Age or sex: The benefits payable under this Policy are based on Your Age and sex (or the Age of the older Insured, if joint coverage) as shown in the application. If Your Age or sex has been misstated the amount of any benefit will be that which the premiums would have bought at the correct Age or sex at the rates in effect on the Effective Date of coverage. If Your Age is misstated in such a way that You were not eligible for coverage under this Policy, our liability will be limited to a refund of the premiums paid.

Nonconvertible: This Policy may not be converted.

Nonparticipating: This Policy does not share in our surplus.

Owner: The Owner may exercise all rights and privileges and receive every benefit provided by this Policy or granted by us while You are alive. The exercise of these rights is subject to the rights of the person named as an irrevocable Beneficiary.

Change of Owner: While You are alive, the Owner may name a different Owner by sending a Written Notice, with the Policy for endorsement, to our Administrative Office.

Proof of Death: We must receive due proof of death. This proof must show that You died while this Policy was in Full Force. In addition, the proof of death must be furnished to us in a manner which is satisfactory to us. We will provide specific instructions for claiming proceeds on request.

Suicide: If the Insured commits suicide, whether sane or insane, within two years from the Date of Issue our liability is limited to the refund of all premiums paid for the Insured's coverage. The surviving Insured may continue single life coverage.

Conformity with Law: If any part of this Policy conflicts with the law in the state where You lived at Date of Issue, the Policy is automatically changed to conform to that law.

TERMINATION PROVISIONS

Termination of Coverage: The insurance coverage under this Policy will terminate on the date the first of the following occurs:

- (a) the Eligible Loan that this insurance was written to cover is paid in full, or otherwise terminated, except through Refinance;
- (b) the premiums for the Policy are not paid during the 31-day Grace Period;
- (c) we receive written request from the Owner to terminate the Policy;
- (d) the first Policy Anniversary of Your Policy following Your 70th birthday (or the Policy Anniversary following the 70th birthday of the older Insured in case of joint coverage);
- (e) the death of the Insured (or one or both of the Joint Insureds if joint coverage); or
- (f) the end of the Expiration Date.

Liberty Life Insurance Company

PO Box 19084, Greenville, South Carolina 29602-9084

**This is a Policy for Decreasing Term Life Insurance.
Premiums for Single or Joint Coverage
Premiums are level until the end of the 10th Policy Year.
After the 10th Policy Year premiums may increase (subject to
Guaranteed Maximum Premium) annually on the Policy Anniversary.
Payable at death, or First Death, if Joint Coverage.
This is Nonparticipating and Nonconvertible Coverage.**



Liberty Life Insurance Company
Decreasing Term Life Insurance Application

[PO Box 19099, Greenville, SC 29602-9099] **6**

Questions? Contact us at: [1-866-578-5840]

2

1

MORTGAGE INFORMATION

[Reference Number]	Insurance Term	Mortgage Amount \$	Initial Insurance Amount \$	Loan Term	Loan Interest Rate	Loan Closing Date
Mortgage Property Address Street			City	State	Zip	[Loan Officer] 3
						[Loan Officer ID] 4

FIRST APPLICANT (Please Print)

SECOND APPLICANT (Please Print)

First Name	Middle Initial	Last Name	First Name	Middle Initial	Last Name
Residence Address Street			Residence Address Street		
City	State	Zip	City	State	Zip
Mailing Address (if different)			Mailing Address (if different)		
City	State	Zip	City	State	Zip
Date of Birth	Social Security Number	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth	Social Security Number	<input type="checkbox"/> Female <input type="checkbox"/> Male
Home Phone Number	Business Phone Number		Home Phone Number	Business Phone Number	
Email Address	State of Birth		Email Address	State of Birth	
First Applicant's Beneficiary			Second Applicant's Beneficiary		
Relationship of First Applicant's Beneficiary			Relationship of Second Applicant's Beneficiary		

FIRST APPLICANT		SECOND APPLICANT	
YES	NO	YES	NO

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1) In the past 12 months, have you used any tobacco or nicotine products? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) In the past 5 years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; required follow-up for; or had any known indication of: | | | | |
| • disease or disorder of the heart, blood, or blood vessels; high blood pressure; stroke or TIA (transient ischemic attack); cancer; tumor; asthma or any lung or respiratory disease or disorder; | | | | |
| • diabetes; disease or disorder of the kidney, bladder, prostate, or reproductive organs; hepatitis or any disease or disorder of the liver, pancreas, stomach or digestive system; arthritis or any disease or disorder of the muscles, connective tissues, or bones; | | | | |
| • alcohol or drug abuse; anxiety, depression or other mental or nervous disorder; seizures, multiple sclerosis, paralysis, or any other disease or disorder of the nervous system; or Alzheimer's disease or any other form of dementia? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you been diagnosed as having AIDS, AIDS Related Complex (ARC) or any other disorder of your immune system, or have you had a positive HIV test? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Will this insurance replace any other life insurance or annuity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If "yes", give company name and amount:

First Applicant: _____

Second Applicant: _____

First Name	Middle Initial	Last Name	[Reference Number]
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The Applicant(s) represent(s) that the following are the complete details to “Yes” answers in Questions 1 and 2:

5

Premium Payment Method:

Credit Card
 Checking / Savings Account
 Premium Amount: _____ Frequency: _____

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 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 receipt of the insurance/credit disclosures provided with 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.

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 fines and confinement in prison.

7

FIRST APPLICANT’S SIGNATURE 	DATE / /	SECOND APPLICANT’S SIGNATURE 	DATE / /
Agent: Will this insurance replace any other life insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No (If “yes”, complete the required state replacement form.)			
AGENT’S SIGNATURE 	DATE / /	AGENT’S PRINTED NAME	



Liberty Life Insurance Company
Decreasing Term Life Insurance Application

PO Box 19099, Greenville, SC 29602-9099

Questions? Contact us at: 1-866-578-5840

MORTGAGE INFORMATION

Reference Number 012468	Insurance Term 30 Yrs.	Mortgage Amount \$100,000	Initial Insurance Amount \$100,000	Loan Term 30 Yrs.	Loan Interest Rate 5.0%	Loan Closing Date 1/5/09
Mortgage Property Address Street 123 Any Street			City New Town	State Any	Zip 12345	Loan Officer 123
						Loan Officer ID AB

FIRST APPLICANT (Please Print)

SECOND APPLICANT (Please Print)

First Name John	Middle Initial Q.	Last Name Doe	First Name	Middle Initial	Last Name
Residence Address Street 1 Main Street					
City Anytown		State Any	Zip 11115		
Mailing Address (if different)			Mailing Address (if different)		
City		State	Zip		
Date of Birth 10/1/1973	Social Security Number 123-45-6789	<input type="checkbox"/> Female <input checked="" type="checkbox"/> Male	Date of Birth	Social Security Number	<input type="checkbox"/> Female <input type="checkbox"/> Male
Home Phone Number (111) 222-3456	Business Phone Number (111) 212-4444		Home Phone Number	Business Phone Number	
Email Address Jdoe@email.net		State of Birth SC	Email Address		State of Birth
First Applicant's Beneficiary Jane Q. Doe			Second Applicant's Beneficiary		
Relationship of First Applicant's Beneficiary Wife			Relationship of Second Applicant's Beneficiary		

FIRST APPLICANT		SECOND APPLICANT	
YES	NO	YES	NO

- | | | | | |
|--|--------------------------|-------------------------------------|--------------------------|--------------------------|
| 1) In the past 12 months, have you used any tobacco or nicotine products? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) In the past 5 years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; required follow-up for; or had any known indication of: | | | | |
| • disease or disorder of the heart, blood, or blood vessels; high blood pressure; stroke or TIA (transient ischemic attack); cancer; tumor; asthma or any lung or respiratory disease or disorder; | | | | |
| • diabetes; disease or disorder of the kidney, bladder, prostate, or reproductive organs; hepatitis or any disease or disorder of the liver, pancreas, stomach or digestive system; arthritis or any disease or disorder of the muscles, connective tissues, or bones; | | | | |
| • alcohol or drug abuse; anxiety, depression or other mental or nervous disorder; seizures, multiple sclerosis, paralysis, or any other disease or disorder of the nervous system; or Alzheimer's disease or any other form of dementia? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you been diagnosed as having AIDS, AIDS Related Complex (ARC) or any other disorder of your immune system, or have you had a positive HIV test? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Will this insurance replace any other life insurance or annuity? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If "yes", give company name and amount:

First Applicant: _____

Second Applicant: _____

First Name John	Middle Initial Q.	Last Name Doe	Reference Number 012468
--------------------	----------------------	------------------	----------------------------

The Applicant(s) represent(s) that the following are the complete details to “Yes” answers in Questions 1 and 2:

Premium Payment Method:

- Credit Card
- Checking / Savings Account

Premium Amount: \$15.08 Frequency: Monthly

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 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 receipt of the insurance/credit disclosures provided with 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.

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 fines and confinement in prison.

FIRST APPLICANT’S SIGNATURE	DATE
<i>x John Q. Doe</i>	1/1/09

SECOND APPLICANT’S SIGNATURE	DATE
<i>x</i>	/ /

Agent: Will this insurance replace any other life insurance or annuity? Yes No
(If “yes”, complete the required state replacement form.)

AGENT’S SIGNATURE	DATE
<i>Joe Agent</i>	1/1/09

AGENT’S PRINTED NAME
Joe Agent

1 Confirm Your Information 1

Please verify this information is accurate. If it is not correct call [1-866-578-5840] for instructions.

[Customer Number] 2
 Mortgage Amount
 Loan Term
 Loan Interest Rate
 [Loan Closing Date] 3
 Mortgage Property Address

2 Choose Your Coverage

Initial Insurance Amount 4
 Insurance Term
[Applicant Premium Amount Frequency]

5

Beneficiary (the recipient of the death benefit)

First Applicant's Beneficiary	Relationship
Second Applicant's Beneficiary	Relationship

Are you planning to replace, discontinue, or change an existing policy or contract?

Yes No

If "Yes", give details:

First Applicant Company	Amount
Second Applicant Company	Amount

3 Provide Some Additional Information

We need some additional information to process your insurance application. Please print clearly so we can process your application as quickly as possible.

First Applicant's Residence Address Second Applicant's Residence Address (if applicable)

Mailing Address (if different than shown above)			Mailing Address (if different than shown above)		
Date of Birth	Social Security Number	Sex	Date of Birth	Social Security Number	Sex
Daytime Phone Number		Evening Phone Number	Daytime Phone Number		Evening Phone Number
E-mail Address		State of Birth	E-mail Address		State of Birth

4 Choose Your Payment Method 6

Monthly Automatic Deduction from My/Our Account.
 (Include a voided check or savings deposit slip if choosing this option)
 I authorize my financial institution to debit the premiums from my account by and payable to Liberty Life Insurance Company. 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 I cancel it in writing and my financial institution receives such notice.

Premium Amount (from Step 2): \$ _____ Full Name(s) on Account: _____
 Bank Name: _____ Bank Routing Number: _____
 Checking Savings Account Number: _____

Monthly Charge to My Credit Card.
 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.

Premium Amount (from Step 2): \$ _____ Full Name(s) on Card: _____
 Card Number: _____ Card Expiration: _____
 Visa MC Diners Club

Almost done! Fill out some additional information on the back.

5 Please answer these questions about your health

If you answer "Yes" to one of the questions below, **circle** the applicable condition in the question.

	7	
	First Applicant	Second Applicant
Question 1 In the past 12 months, have you used any tobacco or nicotine products?	Yes No	Yes No
Question 2 In the past 5 years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; required follow-up for; or had any known indication of: § disease or disorder of the heart, blood, or blood vessels; high blood pressure; stroke or TIA (transient ischemic attack); cancer; tumor; asthma or any lung or respiratory disease or disorder; § diabetes; disease or disorder of the kidney, bladder, prostate, or reproductive organs; hepatitis or any disease or disorder of the liver, pancreas, stomach or digestive system; arthritis or any disease or disorder of the muscles, connective tissues, or bones; § alcohol or drug abuse; anxiety, depression or other mental or nervous disorder; seizures, multiple sclerosis, paralysis, or any other disease or disorder of the nervous system; or Alzheimer's disease or any other form of dementia?	Yes No	Yes No
Question 3 Have you been diagnosed as having AIDS, AIDS Related Complex (ARC) or any other disorder of your immune system, or have you had a positive HIV test?	Yes No	Yes No

6 Give more details

If you answered "Yes" to the health questions, give more details in the space below. The Applicant(s) represent(s) that the following are the complete details. Be sure to specify applicant's name and referenced question.

T Each Applicant Acknowledges and Authorizes the Following:

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 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 receipt of the insurance/credit disclosures provided with this application.

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 fines and confinement in prison.

Signature(s)

X _____ /_____/____ X _____ /_____/____

First Applicant's Signature Date Second Applicant's Signature Date

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.

That's It! You're Finished!
 Now just mail the application in the envelope provided and we will process it immediately.
 Questions? Call 1-866-578-5840

1 Confirm Your Information

Please verify this information is accurate.
If it is not correct call 1-866-578-5840 for instructions.

Customer Number	897495730001
Mortgage Amount	\$100,000
Loan Term	30 Yrs.
Loan Interest Rate	5.00%
Loan Closing Date	1/5/09
Mortgage Property Address	
123 Any Street	
New Town, Any 12345	

2 Choose Your Coverage

Initial Insurance Amount	\$100,000
Insurance Term	30 Yrs.
 John	 \$15.08 Monthly

Beneficiary (the recipient of the death benefit)

John's Beneficiary	Relationship
Jane Q. Doe	Wife

Are you planning to replace, discontinue, or change an existing policy or contract?

Yes No

If "Yes", give details:

John's Company	Amount

3 Provide Some Additional Information

We need some additional information to process your insurance application.
Please print clearly so we can process your application as quickly as possible.

First Applicant's Residence Address

John Q. Doe
1 Main St.
Anytown, Any 11115

Mailing Address (if different than shown above)		
Date of Birth	Social Security Number	Sex
10/1/1973	123-45-6789	M
Daytime Phone Number		Evening Phone Number
(111) 222-3456		
E-mail Address		State of Birth
Jdoe@email.net		SC

Second Applicant's Residence Address (if applicable)

Mailing Address (if different than shown above)		
Date of Birth	Social Security Number	Sex
Daytime Phone Number		Evening Phone Number
E-mail Address		State of Birth

4 Choose Your Payment Method

Monthly Automatic Deduction from My/Our Account.
(Include a voided check or savings deposit slip if choosing this option)
I authorize my financial institution to debit the premiums from my account by and payable to Liberty Life Insurance Company. 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 I cancel it in writing and my financial institution receives such notice.

Premium Amount (from Step 2): \$ 15.08 Full Name(s) on Account: John Q. Doe
Bank Name: ABC Bank Bank Routing Number: 011102225
 Checking Savings Account Number: 012345670

Monthly Charge to My Credit Card.
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.

Premium Amount (from Step 2): \$ _____ Full Name(s) on Card: _____
Card Number: _____ Card Expiration: _____
 Visa MC Diners Club

Almost done! Fill out some additional information on the back.

5 Please answer these questions about your health

If you answer "Yes" to one of the questions below, **circle** the applicable condition in the question.

Question 1	First Applicant	Second Applicant
In the past 12 months, have you used any tobacco or nicotine products?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Question 2 In the past 5 years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; required follow-up for; or had any known indication of: <ul style="list-style-type: none"> ▪ disease or disorder of the heart, blood, or blood vessels; high blood pressure; stroke or TIA (transient ischemic attack); cancer; tumor; asthma or any lung or respiratory disease or disorder; ▪ diabetes; disease or disorder of the kidney, bladder, prostate, or reproductive organs; hepatitis or any disease or disorder of the liver, pancreas, stomach or digestive system; arthritis or any disease or disorder of the muscles, connective tissues, or bones; ▪ alcohol or drug abuse; anxiety, depression or other mental or nervous disorder; seizures, multiple sclerosis, paralysis, or any other disease or disorder of the nervous system; or Alzheimer's disease or any other form of dementia? 	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Question 3 Have you been diagnosed as having AIDS, AIDS Related Complex (ARC) or any other disorder of your immune system, or have you had a positive HIV test?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6 Give more details

If you answered "Yes" to the health questions, give more details in the space below. The Applicant(s) represent(s) that the following are the complete details. Be sure to specify applicant's name and referenced question.

7 Each Applicant Acknowledges and Authorizes the Following:

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 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 receipt of the insurance/credit disclosures provided with this application.

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 fines and confinement in prison.

Signature(s)

X John Doe 1/10/09 X _____
 First Applicant's Signature Date Second Applicant's Signature Date

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.

That's It! You're Finished!
 Now just mail the application in the envelope provided and we will process it immediately.
Questions? Call 1-866-578-5840

SERFF Tracking Number: *LBLI-126003369* *State:* *Arkansas*
Filing Company: *Liberty Life Insurance Company* *State Tracking Number:* *41418*
Company Tracking Number: *MLDT(03-09)*
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.314 Decreasing - Joint (First to Die) -
Fixed/Indeterminate Premium*

Product Name: *RBC Mortgage Decreasing Term*
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: LBLI-126003369 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 41418
Company Tracking Number: MLDT(03-09)
TOI: L04I Individual Life - Term Sub-TOI: L04I.314 Decreasing - Joint (First to Die) -
Fixed/Indeterminate Premium
Product Name: RBC Mortgage Decreasing Term
Project Name/Number: /

Supporting Document Schedules

Satisfied -Name: Flesch Certification	Review Status:	01/22/2009
Comments:		
Attachment: READABILITY-AR (G).pdf		
Satisfied -Name: Expl of Brackets - RBCMPG	Review Status:	01/28/2009
Comments:		
Attachment: Expl of Brackets-RBCMPG.pdf		
Satisfied -Name: Expl of Brackets - RBCMPD	Review Status:	01/28/2009
Comments:		
Attachment: Expl of Brackets-RBCMPD.pdf		
Satisfied -Name: MDLT- Statement of Policy Cost and Benefit	Review Status:	01/28/2009
Comments:		
Attachment: Cost disclosure.pdf		

READABILITY COMPLIANCE CERTIFICATION

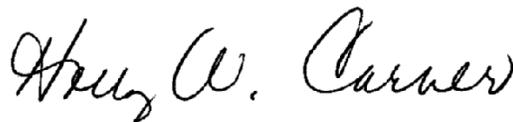
1. Insurer: Liberty Life Insurance Company
PO Box 789
Greenville, South Carolina 29602-0789
2. Certification: I hereby certify that the forms listed below produce Flesch reading ease scores which meet the minimum score required in your state.

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>
RBC Mortgage Decreasing Term	MLDT(03-09)	57.2
Application for Decreasing Term	RBCMPG(01-09)AR	56.9*
Application for Decreasing Term (Direct)	RBCMPD(01-09)AR	50.5*

*combined with the policy



1/30/2009
Date

Holly Carver
Compliance Specialist II Policy Forms/Compliance

Life Insurance Application
Form No. RBCMPG(01-09)
Explanation of Brackets

1. **800 #:** Although this is our standard in-bound toll-free customer service number, we may utilize an optional number for this product based on call volume.
2. **Reference Number:** We may or may not utilize this number. Therefore, it may not appear on the application.
3. **Loan Officer:** We may utilize this box to identify the licensed agent. Therefore, it may not appear on the application.
4. **Loan Officer ID:** We may utilize this box to assign a number to identify the licensed agent. Therefore, it may not appear on the application.
5. **Premium payment method, amount and frequency:** The payment authorization language will vary depending upon the payment election made by the applicant and the options available. In most situations, the payment authorization wording and personal account information will not appear on the application, but will appear on a separate document that will be signed by the insured. The premium payment method, frequency and amount will always appear on the application. In addition to the example shown on the application, the premium payment section may also appear as shown in Examples A-D as follows:

A. Premium Payment Method:

- Credit Card
- Checking/Savings Account
- Mortgage Payment

Premium Amount: \$ _____ Frequency: _____

B. For EFT payments:

- Monthly Automatic deduction from my/our account.

I authorize my financial institution to debit the premiums from my account by and payable to Liberty Life Insurance Company. 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 I cancel it in writing and my financial institution receives such notice.

Premium Amount: \$ _____ Full Name(s) on Account: _____

Bank Name: _____

Bank Routing Number: _____ Checking Savings Account Number: _____

C. For Credit Card payments:

- 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

Premium Amount: \$ _____

D. For mortgage payments:

- Collect monthly premiums with my/our Mortgage Payment

I/we authorize my/our lending institution to add the premium to my/our mortgage payment for the amount of insurance as indicated. If I/we have authorized my/our lending institution to automatically/electronically debit from my/our account, I/we hereby request this insurance premium to be added to this authorization.

Premium Amount: \$ _____

6. **PO Box 19099:** This PO Box number address may vary depending on the volume expected from the marketing campaign.
7. This signature section will vary depending on whether or not the applicant signs the application traditionally with a wet signature, an electronic “click” signature, or a voice signature. The sample application included shows the way the application may appear if the applicant signs traditionally and the agent’s signature is captured electronically. The following examples show the way the application may appear if the applicant signs electronically, or through voice signature and the agent signs electronically:

Example of Electronic signature:

FIRST APPLICANT’S SIGNATURE	DATE	SECOND APPLICANT’S SIGNATURE	DATE
Digitally signed by John Doe on	mm/dd/yy	Digitally signed by Jane Doe on	mm/dd/yy

Agent: Will this insurance replace any other life insurance or annuity? Yes No
(If “yes”, complete the required state replacement form.)

AGENT’S SIGNATURE	DATE	AGENT’S PRINTED NAME	
Digitally signed by John Agent on	mm/dd/yy	John Agent	mm/dd/yy

Example of Voice Signature:

FIRST APPLICANT’S SIGNATURE	DATE	SECOND APPLICANT’S SIGNATURE	DATE
Verbally signed by John Doe on	mm/dd/yy	Verbally signed by Jane Doe on	mm/dd/yy

Agent: Will this insurance replace any other life insurance or annuity? Yes No
(If “yes”, complete the required state replacement form.)

AGENT’S SIGNATURE	DATE	AGENT’S PRINTED NAME	
Digitally signed by John Agent on	mm/dd/yy	John Agent	mm/dd/yy

Life Insurance Application
Form No. RBCMPD(01-09)
Explanation of Brackets

1. **800 #:** Although this is our standard in-bound toll-free customer service number, we may utilize an optional number for this product based on call volume.
2. **Customer Number:** We may or may not utilize this number. Therefore, it may not appear on the application. Customer Number may also be referred to as Reference Number.
3. **Loan Closing Date:** The Loan Closing Date will not always be provided and therefore may not be printed on the application.
4. **Choose Your Coverage – Premium/Frequency:** Personalized premium amount and frequency may be displayed for each applicant. If joint coverage is being offered, the joint premium may also be displayed. Our sample shows single coverage; however, this section could appear as follows:
 - John only \$xx.xx monthly
 - Jane only \$xx.xx monthly
 - John and Jane \$xx.xx monthly
5. **Choose Your Coverage - Beneficiary:** This section will be personalized based on the applicant. Our sample shows how it may appear if a second applicant is applicable; however, if there is not a second applicant, both will not appear.
6. **Payment modes, amount and frequency:** The payment authorization language will vary depending on whether or not the premium is to be paid directly to Liberty Life or remitted via the policy owner's financial institution. The sample application included shows the way the application may appear when the applicant remits premiums directly to Liberty Life, with choices given for payment by credit card or automatic bank draft (EFT). If arrangements are made for premiums to be collected and remitted to Liberty Life by the applicant's financial institution, then the following payment authorization language may be used:

Authorize Your Payment

- Add My Premium to My Mortgage Payment

I/We authorize my/our lending institution to add the premium to my/our mortgage payment for the amount of insurance as indicated. If I/we have authorized my/our lending institution to automatically/electronically debit from my/our account, I/we hereby request this insurance premium to be added to this authorization.

Premium Amount: _____

7. There will always be a specific place on the application provided for each applicant to answer all health questions and the questions will not change. The arrangement of the checkboxes and arrows may change depending on usability testing for clarity. Also, instead of the checkboxes appearing to the right of the health questions, they may be placed below each question.

STATEMENT OF POLICY COST AND BENEFIT INFORMATION

ANY CORRESPONDENCE REGARDING THIS POLICY SUMMARY MAY BE FORWARDED EITHER TO OUR ADMINISTRATIVE OFFICE OR THE AGENT LISTED BELOW.

PREPARED BY

LIBERTY LIFE INSURANCE COMPANY
PO BOX 19084
GREENVILLE, SC 29602-9084

JOE AGENT
1234 SOUTH STREET
ANYTOWN, SOUTH CAROLINA 12345

THIS POLICY SUMMARY WAS PREPARED ON 01/15/2009, FOR THE LIFE OF JOHN Q. DOE (MALE), ISSUE AGE 35, PREMIUM CLASS STANDARD NON-TOBACCO, POLICY NUMBER 123456789.

YOUR COVERAGE CONSISTS OF THE FOLLOWING

BASIC POLICY PLAN AND BENEFITS	ANNUAL PREMIUM	YEARS PAYABLE
DECREASING TERM INSURANCE POLICY	\$ 181.00	30*

*THE ANNUAL PREMIUM ABOVE IS FOR THE FIRST 10 POLICY YEARS. AFTER THE FIRST 10 POLICY YEARS YOUR PREMIUM MAY INCREASE ANNUALLY, BUT WILL NOT EXCEED THE GUARANTEED MAXIMUM ANNUAL PREMIUM OF \$369.00.

GUARANTEED AMOUNT PAYABLE ON DEATH OF THE INSURED

BEGINNING OF POLICY YEAR	BASIC POLICY
1	\$100,000
2	\$98,600
3	\$97,000
4	\$95,400
5	\$93,700
10	\$83,700
20	\$54,400
30 (AGE 65)	\$6,200

LIFE INSURANCE COST INDEXES BASED ON GUARANTEED AMOUNT PAYABLE ON DEATH.

COST INDEXES	BASIC POLICY
SURRENDER END OF POLICY YEAR 10	1.94
NET PAYMENT END OF POLICY YEAR 10	1.94
SURRENDER END OF POLICY YEAR 20	2.99
NET PAYMENT END OF POLICY YEAR 20	2.99

AN EXPLANATION OF THE INTENDED USE OF THESE INDEXES IS PROVIDED IN THE LIFE INSURANCE BUYER'S GUIDE. THESE INDEXES ARE USEFUL ONLY FOR THE COMPARISON OF RELATIVE COSTS OF TWO OR MORE SIMILAR POLICIES.

31-DAY RIGHT TO EXAMINE POLICY

YOU MAY RETURN THE POLICY DESCRIBED IN THIS SUMMARY WITHIN 31 DAYS AFTER RECEIPT BY DELIVERING OR MAILING IT TO US OR TO OUR AGENT. THE POLICY WILL THEN BE VOID AS OF ITS DATE OF ISSUE, AND WE WILL REFUND ANY PREMIUM PAID.