

SERFF Tracking Number: LBLI-126064323 State: Arkansas
 Filing Company: Liberty Bankers Life Insurance Company State Tracking Number: 41785
 Company Tracking Number:
 TOI: L071 Individual Life - Whole Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life
 Product Name: HS Application
 Project Name/Number: /

Filing at a Glance

Company: Liberty Bankers Life Insurance Company

Product Name: HS Application

SERFF Tr Num: LBLI-126064323 State: Arkansas

TOI: L071 Individual Life - Whole

SERFF Status: Closed-Approved-Closed
 State Tr Num: 41785

Sub-TOI: L071.101 Fixed/Indeterminate
 Premium - Single Life

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Author: Chad Leiding

Reviewer(s): Linda Bird

Date Submitted: 03/06/2009

Disposition Date: 03/13/2009

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/13/2009

Explanation for Other Group Market Type:

State Status Changed: 03/13/2009

Deemer Date:

Created By: Chad Leiding

Submitted By: Chad Leiding

Corresponding Filing Tracking Number:

Filing Description:

LBL-HS-APP-1008

The above listed form is submitted for your review and approval. This form is new and is not intended to replace any previously approved form.

Policy application form LBL-HS-APP-1008 is a new application that will be used by our home service agents for the marketing of previously approved whole life policy form LBL SIWL-0806-AR (Approved on 1/5/07).

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To the best of our knowledge, this filing is complete, does not contain any unusual that may differ from industry standards and is intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Chad Leiding, V.P Compliance chad.leiding@libertybankerslife.com
 1800 Valley View Lane 469-522-4332 [Phone]
 Suite 300 469-522-4380 [FAX]
 Dallas, TX 75234

Filing Company Information

Liberty Bankers Life Insurance Company CoCode: 68543 State of Domicile: Oklahoma
 1800 Valley View Lane Group Code: 3436 Company Type: LAH
 Suite 300 Group Name: State ID Number:
 Dallas, TX 75234 FEIN Number: 25-1093227
 (469) 522-4332 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$25.00
 Retaliatory? Yes
 Fee Explanation: OK charges \$25 for applications.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty Bankers Life Insurance Company	\$25.00	03/06/2009	26197083

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	03/13/2009	03/13/2009

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Disposition

Disposition Date: 03/13/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Application		Yes

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Form Schedule

Lead Form Number: LBL-HS-APP-1008

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LBL-HS-APP-1008	Application/ Enrollment Form	Application Enrollment Form	Initial		44.800	LBL-HS-APP-1008-GENERIC.pdf

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

Proposed Insured (First Name, Initial, Last Name) _____

State of Birth _____ Country of Birth _____

Date of Birth _____ Current Age _____

Sex _____ Height _____ Weight _____

Social Security No. _____

Street Address _____

City, State, Zip _____

Home/Cell Phone _____

Work Phone: _____

E-Mail Address _____

Occupation _____

1. Have you used tobacco in any form in the past 12 months? YES NO

2. Are you a US Citizen including resident alien? YES NO
If No, please explain type of visa or work permit: _____

Plan Applied For: _____

Face Amount \$ _____

Benefits/Riders Child Rider
Number of Units _____

ADD & CC Benefit Amount \$ _____

WP

Premium Collected \$ _____

Premium Mode:

Agent Billed

Monthly Bank Draft
Draft Day: _____

Monthly Quarterly

Semi-Annual Annual

Primary Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

Contingent Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

OWNER of Policy (if other than Proposed Insured)

Relationship _____

Social Security No. _____

Street Address _____

City, State, Zip _____

Home/Cell Phone _____

E-Mail _____

CHILD RIDER (Attach additional sheet, if necessary with applicant's signature)

Full Name	Date of Birth	Age	Sex	Amount	Relationship	Height	Weight

**Please read each question carefully and answer truthfully before signing application.
If any applicant answers YES to any question in Part 1, DO NOT PROCEED with the application on that applicant.**

Part 1

	YES	NO
To the best of your knowledge and belief, has any Proposed Insured:		
1. Ever been diagnosed with congestive heart failure, cystic fibrosis, Alzheimer's, senile dementia, dementia, Down's Syndrome, terminal illness, muscular dystrophy, Huntington's Disease, amyotrophic lateral sclerosis (ALS), or had an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever been diagnosed or received treatment for AIDS (Acquired Immune Deficiency Syndrome), AIDS Related Complex or tested positive for HIV Virus, or any other disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
Are you or any Proposed Insured currently or within the last 90 days:		
3. Been unable to care for yourself, bedridden at home, confined in a penal institution, hospital, nursing home, hospice, assisted living or long-term care facility, or using oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
4. Had undiagnosed chest pain, fainting, paralysis, coughed up or vomited blood?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does any Proposed Insured currently have uncontrolled high blood pressure or uncontrolled diabetes, diabetic coma, insulin shock, or diagnosis of diabetes at age 9 or younger, or diabetes associated with retinopathy, nephropathy, neuropathy or amputation?	<input type="checkbox"/>	<input type="checkbox"/>

Part 2

	YES	NO
To the best of your knowledge and belief, within the last 3 years have you or any Proposed Insured 1) had, 2) been diagnosed for, 3) had or have any new symptoms for, or 4) awaiting surgery, medical tests or test results for:		
1. Heart attack, irregular heartbeat, aneurysm, any condition leading to angioplasty or bypass surgery, cardiomyopathy, cardiac defibrillator, heart valve surgery, stroke, cerebrovascular insufficiency or blockage, high blood pressure or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
2. Internal cancer, melanoma, leukemia, sickle cell anemia, kidney insufficiency or failure, hepatitis C, kidney disease (excluding passed kidney stones), liver disease including cirrhosis; chronic pancreatitis, Hodgkin's disease, lymphoma, lung disease including emphysema, digestive system or stomach?	<input type="checkbox"/>	<input type="checkbox"/>
3. Paralysis, Parkinson's, Grand Mal epilepsy, convulsions, multiple sclerosis, lupus or connective tissue disorder, brain disorder or suffer from mental retardation, behavior or mental disorders or Rheumatoid Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
4. Schizophrenia, psychosis, suicidal thoughts or attempts, including hospitalization for major depression?	<input type="checkbox"/>	<input type="checkbox"/>
5. Alcoholism, drug abuse, narcotic addiction, or been convicted of felony?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you or any Proposed Insured currently using a wheelchair or walker on a permanent basis?	<input type="checkbox"/>	<input type="checkbox"/>
7. Within the last one year, have you or any Proposed Insured had an application for life insurance declined or refused for any reason?	<input type="checkbox"/>	<input type="checkbox"/>

Give Details to Questions Answered "YES" above: (Attach additional sheet, if necessary with applicant's signature) _____

1. Does any Proposed Insured have existing life insurance policies or annuity contracts? YES NO

2. Will this insurance replace or change any other insurance policies or annuity contracts? YES NO

If "YES" to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required: _____

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.

Any insurance must first be approved for issuance by Liberty Bankers Life Insurance Company on the basis of this application. Coverage will begin when the policy has been issued, received and accepted by the proposed insured or applicant with the first full premium paid to Liberty Bankers Life Insurance Company, while the proposed insured's health and other conditions remain as described in this application. Liberty Bankers Life Insurance Company is authorized to correct errors and omissions as necessary and acceptance of any policy issued on this application shall constitute ratification thereof, except that any amendment as to amount, classification, plan of insurance or benefits shall be made only with the written consent of the proposed insured or the applicant.

I authorize any physician, medical practitioner, hospital, clinic, other medical medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or employer to give the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. I further acknowledge that I may revoke this authorization at any time by submitting a written request to the Company. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 24 months from the date shown below. I know that I or my representative may request a copy of this authorization.

I certify that I have reviewed the questions and responses contained on this application and that my responses to these questions have been accurately recorded. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.

X _____
Signature of Proposed Insured Date City/State

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

Agent Statement:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Did you give the applicant a copy of the Privacy Notice and other disclosure information? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you related to the Proposed Insured? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Was this application taken in person? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you know anything not disclosed which might affect the underwriting of this risk? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does the Proposed Insured have any existing life insurance policies or annuity contracts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is replacement of existing insurance involved in this application? If yes: Have you submitted the appropriate replacement forms? | <input type="checkbox"/> | <input type="checkbox"/> |

X _____
Printed Agent's Name Agent's Signature Agent's Number

LBL-HS-APP-1008

CONDITIONAL RECEIPT – (Cross through if payment is NOT received).

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY, UNLESS THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY:

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

- That on the effective date the Proposed Insured is insurable as a standard risk under the Company's rules for the plan amount and premium rate applied for.
- That the sum paid is equal to the FULL FIRST PREMIUM for the policy applied for.

INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ON THE LATEST OF:

- date of the application; or (b) date requested in the application; or
- date of the last of any medical examinations or tests required under the rules and practices of the Company.

The total amount of insurance which may become effective prior to delivery of the policy to the Owner shall not exceed \$25,000. This amount includes LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS then IN FORCE or APPLIED FOR with this Company. **LIBERTY BANKERS LIFE INSURANCE COMPANY** has received \$ _____ for Applicant _____

By _____
Agent Date

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

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION
This authorization complies with the HIPAA Privacy Rule

I hereby authorize any: medical practitioner, physician, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on LIBERTY BANKERS LIFE INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that LIBERTY BANKERS LIFE underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations.

I understand that:

- such information will be used by LIBERTY BANKERS LIFE INSURANCE COMPANY for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- a picture copy or photocopy of this authorization shall be as valid as the original; and
- any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of LIBERTY BANKERS LIFE INSURANCE COMPANY, P. O. Box 5147, Springfield, IL 62705. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Proposed Insured (Please print)

Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

Date

Date of Birth

Additional Proposed Insured (Please print)

Signature of Additional Person Proposed for Insurance

Date of Birth

Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other _____ (Circle one)

LBL-HS-APP-1008

This Notice Must be Given to Proposed Insured

FAIR CREDIT REPORTING ACT PRE-NOTIFICATION FORM. Thank you for considering Liberty Bankers Life Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-5088 requires that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors, and associates. You are entitled to be interviewed in connection with an investigative consumer report; and, you have the right to receive a copy of any investigative consumer report by making a written request within a reasonable period of time.

NOTICE TO APPLICANTS FOR INSURANCE. Information regarding your insurability will be treated as confidential. Liberty Bankers Life Insurance Company, or its reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request from you, will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts, 02184, telephone 1-866-692-6901, web address: www.mib.com.

Liberty Bankers Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: AR CERTIFICIATION.pdf Readability Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: N/A Comments:		

CERTIFICATION

Company Name: Liberty Bankers Life Insurance Company

I hereby certify that the forms included in this submission and company procedures meet the requirements of Regulation 19, 49, and AR 23-79-138 as well as all applicable requirements of the Arkansas Insurance Department.



Chad Leiding
Vice President Compliance

3/6/09
Date

READABILITY CERTIFICATION

COMPANY NAME Liberty Bankers Life Insurance Company NAIC CO# 68543

FORM NUMBER

FLESCH SCORE

LBL-HS-APP-1008

* 44.8

* scored with policy

A handwritten signature in black ink that reads "Chad Lending". The signature is written in a cursive style with a large initial "C".

Signature of Insurance Company Officer

Vice President Compliance
Typed Name and Title

October 17, 2008
Date