

SERFF Tracking Number: LBLI-126152787 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 42426
Company Tracking Number: ET-APP ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NAIC model replacement update
Project Name/Number: ET-APP et al/ET-APP et al

Filing at a Glance

Company: Liberty Life Insurance Company

Product Name: NAIC model replacement update

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: LBLI-126152787 State: Arkansas

SERFF Status: Closed-Approved-Closed State Tr Num: 42426

Co Tr Num: ET-APP ET AL

State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Julie Duncan, Dianne Harris

Disposition Date: 05/22/2009

Date Submitted: 05/18/2009

Disposition Status: Approved-Closed

Implementation Date:

Implementation Date Requested: 06/18/2009

State Filing Description:

General Information

Project Name: ET-APP et al

Project Number: ET-APP et al

Requested Filing Mode: File & Use

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/22/2009

Deemer Date:

Submitted By: Dianne Harris

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 05/22/2009

Created By: Dianne Harris

Corresponding Filing Tracking Number: ET-APP et al

Filing Description:

Submission of Application Forms for Informational Purposes

Form Numbers:

ET-APP (06-09)AR

ST-APP-P (06-09)AR

CFCMBN (06-09)AR

SERFF Tracking Number: LBLI-126152787 State: Arkansas
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LTAPPN (06-09)AR
IULA2 (06-09)AR
IULS2 (06-09)AR

Dear Sir or Madam:

Liberty Life Insurance Company has prepared the above-referenced filing for your information. The referenced applications will replace the previously approved applications, listed below, as they contain the same content and questions. We request that all other material, including original bracketed material, remain as is currently on file in your department. The only changes to the forms are the replacement question and form number. The changes are the result of your adoption of the Life Insurance and Annuities Replacement Model Regulation of the National Association of Insurance Commissioners.

Form Number Approval Date

ET-APP (09-05) 10-31-05
ST-APP-P (02-05) 4-13-05
CFCMBG (12-07) 5-31-07
LTAPPG (12-07) 6-28-07
IUL-A (12-06) 3-21-07
IUL-S (12-06) 3-21-07

All changes are highlighted.

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. If you have any questions, please contact me at 864-609-3524 or by email at libertydoresponses@rbc.com Attn: Julie Duncan. We will begin using these forms upon receiving your acknowledgement of this filing.

Company and Contact

Filing Contact Information

Julie Duncan, Compliance Analyst II julie.duncan@rbc.com
2000 Wade Hampton Blvd 864-609-1172 [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:

SERFF Tracking Number: *LBLI-126152787* State: *Arkansas*
 Filing Company: *Liberty Life Insurance Company* State Tracking Number: *42426*
 Company Tracking Number: *ET-APP ET AL*
 TOI: *L08 Life - Other* Sub-TOI: *L08.000 Life - Other*
 Product Name: *NAIC model replacement update*
 Project Name/Number: *ET-APP et al/ET-APP et al*
 Greenville, SC 29602 Group Name: State ID Number:
 (864) 609-4815 ext. [Phone] FEIN Number: 44-0188050

Filing Fees

Fee Required? Yes
 Fee Amount: \$120.00
 Retaliatory? No
 Fee Explanation: 6 forms x \$20 = \$120
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty Life Insurance Company	\$120.00	05/18/2009	27949611

SERFF Tracking Number: LBLI-126152787 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 42426
Company Tracking Number: ET-APP ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NAIC model replacement update
Project Name/Number: ET-APP et al/ET-APP et al

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/22/2009	05/22/2009

SERFF Tracking Number: *LBLI-126152787* *State:* *Arkansas*
Filing Company: *Liberty Life Insurance Company* *State Tracking Number:* *42426*
Company Tracking Number: *ET-APP ET AL*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *NAIC model replacement update*
Project Name/Number: *ET-APP et al/ET-APP et al*

Disposition

Disposition Date: 05/22/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LBLI-126152787 State: Arkansas
 Filing Company: Liberty Life Insurance Company State Tracking Number: 42426
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Form	Application		Yes

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Form Schedule

Lead Form Number: ET-APP et al

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	ET-APP(06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update to NAIC Mode Replacement Reg		ET-APP (06-09) AR.pdf
	ST-APP-P(06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update to NAIC Model Replacement Reg		ST-APP-P(06-09)AR.pdf
	CFCMBN(06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update to NAIC Model Replacement Reg		CFCMBN(06-09)AR.pdf
	LTAPPN(06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update to NAIC Model Replacement Reg		LTAPPN(06-09)AR.pdf
	IULA2(06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update to NAIC Model Replacement Reg		IULA2(06-09)AR.pdf
	IULS2(06-09)AR	Application/ Enrollment Form	Other	Other Explanation: Update of NAIC Model Replacement Reg		IULS2(06-09)AR.pdf

**RBC ExpressTERM
Life Insurance Application**

LIBERTY LIFE INSURANCE COMPANY, Greenville, SC

1-866-816-6767 POST OFFICE BOX 19094 GREENVILLE, SC 29602

Name _____ Email _____ Male Female
FIRST MIDDLE LAST
Daytime Phone _____ Occupation _____
ADDRESS
Height _____ Weight _____ Date of Birth ____ / ____ / ____
CITY STATE ZIP CODE MM DD YYYY
SSN _____ State/Country of Birth _____

RENEWABLE LEVEL TERM LIFE INSURANCE
__10 Yr. __15 Yr. __20 Yr. __30 Yr.

OPTIONAL RIDERS
 Accidental Death Benefit Rider
 Children's Insurance Benefit Rider \$ _____
Youngest Child's date of birth ____ / ____ / ____
MM DD YYYY

FACE AMOUNT \$ _____

BENEFICIARY:

NAME: _____ RELATIONSHIP: _____ SSN: _____ PERCENTAGE: _____
NAME: _____ RELATIONSHIP: _____ SSN: _____ PERCENTAGE: _____
NAME: _____ RELATIONSHIP: _____ SSN: _____ PERCENTAGE: _____
NAME: _____ RELATIONSHIP: _____ SSN: _____ PERCENTAGE: _____

CONTINGENT BENEFICIARY:

NAME: _____ RELATIONSHIP: _____ SSN: _____ PERCENTAGE: _____
NAME: _____ RELATIONSHIP: _____ SSN: _____ PERCENTAGE: _____

SELECT PAYMENT FREQUENCY:

SELECT PAYMENT METHOD:

__ Monthly __ Semi-Annually __ Quarterly __ Annually
TOTAL PREMIUM AMOUNT \$ _____
__ Electronic Funds Transfer (Bank Draft)
__ Credit Card

GENERAL QUESTIONS

1. Are you a U.S. citizen or a permanent U.S. resident that holds a permanent visa? Yes No
2. In the past 12 months have you used any nicotine or tobacco products? Yes No
3. Have you been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)? Yes No
4. In the past 2 years, have you been hospitalized or evaluated in an emergency room or immediate care center for any chronic illness requiring ongoing treatment or care by a physician? Yes No
5. Are you awaiting a diagnosis or been advised to have a surgical operation, a diagnostic test or an evaluation that has not yet been completed? Yes No
6. In the past 10 years, have you received any treatment, medical advice, or consultation for; been diagnosed with; or had any known indication of: diabetes; cancer (excluding basal cell or squamous cell carcinoma of the skin); stroke or transient ischemic attack (TIA); emphysema; chronic bronchitis; chronic lung disease; major depression; bipolar disease or mood disorder; schizophrenia; Alzheimer's disease; dementia; degenerative muscle or nerve disease/disorder; paralysis; lupus; rheumatoid arthritis; alcohol or drug abuse; **OR** any disease or disorder of the following: heart, aorta, coronary arteries, peripheral vascular system, blood, liver, pancreas, kidney, brain, or connective tissue? Yes No
7. In the past 3 years, has your driver's license been suspended or revoked, or have you been convicted of or pleaded "guilty" or "no contest" to any felony, DWI/DUI, or are you in prison or serving a probation/parole program? Yes No
8. In the past 2 years, have you participated in any hazardous activities or extreme sports? Yes No
9. Do you have any existing life insurance or annuity contracts? (If Yes, submit required replacement form.) Yes No

Authorization & Signing

Acknowledgement and Authorization

I represent and agree that the information offered in this application is provided in order to obtain insurance and is true and complete. **I understand that no coverage shall take effect unless and until a policy is issued and the first scheduled premium is paid.** I acknowledge receipt of the enclosed consumer protection and privacy disclosures.

I authorize any insurance company, my current and former employers, the Medical Information Bureau ("MIB"), and any other consumer reporting organization to give to Liberty Life Insurance Company ("Liberty") any and all of the following information about me and my minor children: past and present physical, mental, drug and/or alcohol conditions; other insurance coverage; prescribed drugs; motor vehicle records; employment; avocations; and other personal characteristics. I understand that Liberty will collect this information for the purpose of determining eligibility for insurance. This authorization shall be valid for the next 24 months. I understand that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to Liberty at PO Box 19075, Greenville, SC 29602-9075, subject to the rights of anyone who has relied on this authorization. I understand and agree that Liberty may disclose any such information to Liberty's insurance administrators, its reinsurance companies, its agents, the MIB, and other persons or organizations performing business or legal services in connection with my application. A photographic copy of this authorization will be as valid as the original. I understand that I may request and receive copies.

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.

Before you purchase the policy we ask that you:

- Read and agree to our [Terms of Service](#)
- Read our [Privacy Policy](#)
- Read the [Notice Regarding MIB, Inc. \(Medical Information Bureau\)](#), [Consumer Reports](#), and [Insurance Information Practices](#)

I have read and I agree to Liberty Life Insurance Company's Terms of Service Agreement. I have reviewed the Privacy Policy and I have reviewed the Notice Regarding MIB, Inc., Consumer Reports, and Insurance Information Practices.

This policy is issued subject to verification of medical data and other information.

To sign this document, type in the text exactly as it is displayed under each box, and then click on the signature button below.

Insured's Name:
First M. Last
Date:
mm/dd/yyyy
Insured Agrees:
I agree

Agent's Statement: I have truly and accurately recorded the information given by the Applicant.

To the best of my knowledge, the Applicant (*which applies*) *does* *does not* have any existing life insurance or annuity contracts. **If replacement is involved, required replacement forms must be completed and signed.**

To sign this document, type in the text exactly as it is displayed under each box, and then click on the signature button below.

Agent Name:
First M. Last
Date:
mm/dd/yyyy
Agent Agrees:
I agree

RBC ExpressTERM
Life Insurance Application

LIBERTY LIFE INSURANCE COMPANY, Greenville, SC

1-866-816-6767 ♦ POST OFFICE BOX 19094 ♦ GREENVILLE, SC 29602

1. APPLICANT INFORMATION

Name _____
FIRST MI LAST

_____ ADDRESS _____
CITY STATE ZIP CODE

Email Address _____

Daytime Phone () _____ Male Female

Height _____ Weight _____ Date of Birth ____/____/____
MM DD YYYY

SSN _____ State/Country of Birth _____

2. PLAN OF INSURANCE

RENEWABLE LEVEL TERM LIFE INSURANCE
 10 Yr. 15 Yr. 20 Yr. 30 Yr.

FACE AMOUNT \$ _____

OPTIONAL RIDERS
 Accidental Death Benefit Rider
 Children's Insurance Benefit Rider \$ _____

Youngest Child's date of birth ____/____/____
MM DD YYYY

3. PRIMARY BENEFICIARY (IES)

NAME (FIRST, MI, LAST)	SSN/ TAX ID No.	SEX		DATE OF BIRTH MM / DD / YYYY	RELATIONSHIP TO PRIMARY INSURED	% ALLOCATED (MUST TOTAL 100%)
		MALE	FEMALE			
1.						_____%
2.						_____%
3.						_____%

4. CONTINGENT BENEFICIARY (IES)

NAME (FIRST, MI, LAST)	SSN/ TAX ID No.	SEX		DATE OF BIRTH MM / DD / YYYY	RELATIONSHIP TO PRIMARY INSURED	% ALLOCATED (MUST TOTAL 100%)
		MALE	FEMALE			
1.						_____%
2.						_____%

5. PAYMENT INFORMATION

SELECT PAYMENT FREQUENCY:
 Monthly Semi-Annually Quarterly Annually

TOTAL PREMIUM AMOUNT \$ _____

SELECT PAYMENT METHOD:
(ATTACH THE COMPLETED PAYMENT AUTHORIZATION FORM)
 Electronic Funds Transfer (Bank Draft)
 Credit Card

6. GENERAL QUESTIONS

1. In the past 12 months, have you smoked cigarettes, cigars, pipes or have you used tobacco or nicotine in any form including snuff, dip, chew, nicotine patch, gum, or other substitutes?	<input type="radio"/> Yes <input type="radio"/> No
2. In the past 12 months: have you either been hospitalized for three or more consecutive days, or have you missed more than five consecutive days from work or school other than for vacation or family leave (including normal pregnancy and delivery), or have you been advised to have a surgical operation or a diagnostic test or evaluation that has not yet been completed?	<input type="radio"/> Yes <input type="radio"/> No
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="radio"/> Yes <input type="radio"/> No
4. Has your driver's license been suspended or revoked in the past three years, or have you been convicted of or pleaded "guilty" or "no contest" to any felony or DWI/DUI in the past three years, or are you currently in prison or serving a probation or parole program, or In the past twelve months, have you had three or more moving violations?	<input type="radio"/> Yes <input type="radio"/> No
5. Do you have any existing life insurance or annuity contracts? (If Yes, submit required replacement form)	<input type="radio"/> Yes <input type="radio"/> No

Authorization & Signing

Acknowledgement and Authorization

I represent and agree that the information offered in this application is provided in order to obtain insurance and is true and complete to the best of my knowledge. **I understand that no coverage shall take effect unless and until a policy is issued and the first scheduled premium is paid.** I acknowledge receipt of the enclosed consumer protection and privacy disclosures.

I authorize any insurance company, my current and former employers, the Medical Information Bureau ("MIB"), and any other consumer reporting organization to give to Liberty Life Insurance Company ("Liberty") any and all of the following information about me and my minor children: past and present physical, mental, drug and/or alcohol conditions; other insurance coverage; prescribed drugs; motor vehicle records; employment; avocations; and other personal characteristics. I understand that Liberty will collect this information for the purpose of determining eligibility for insurance. This authorization shall be valid for the next 24 months. I understand that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to Liberty at PO Box 19075, Greenville, SC 29602-9075, subject to the rights of anyone who has relied on this authorization. I understand and agree that Liberty may disclose any such information to Liberty's insurance administrators, its reinsurance companies, its agents, the MIB, and other persons or organizations performing business or legal services in connection with my application. A photographic copy of this authorization will be as valid as the original. I understand that I may request and receive copies.

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.

Proposed Insured's Signature

Date

Agent's Statement: I have truly and accurately recorded the information given by the Applicant.
To the best of my knowledge, the Applicant (*check which applies*) does does not have any existing life or annuity contracts. **If replacement is involved, required replacement forms must be completed and signed.**

Agent Signature

Date

Agent ID Number

LIFE INSURANCE APPLICATION

Liberty Life Insurance Company
Greenville, SC

Trial App Worksite App
(Please **PRINT** all answers to all questions completely and legibly in black ink.)

PART I

1. PROPOSED PRIMARY INSURED

Name _____
FIRST MI LAST

SSN _____ Male Female

Marital Status Married Single Sep. Div. Widowed

State of Birth _____ Date of Birth _____ / _____ / _____
MM DD YY

Daytime Ph. () _____

Evening Ph. () _____

Email Address _____

Residence Address (No PO Box) **(REQUIRED)**

ADDRESS _____

CITY STATE ZIP CODE

Mailing Address (if different from Residence Address)

ADDRESS _____

CITY STATE ZIP CODE

Employer _____

Annual Income \$ _____

2. PROPOSED SPOUSE/OTHER INSURED

Name _____
FIRST MI LAST

SSN _____ Male Female

Marital Status Married Single Sep. Div. Widowed

State of Birth _____ Date of Birth _____ / _____ / _____
MM DD YY

Daytime Ph. () _____

Evening Ph. () _____

Email Address _____

if same address as Proposed Primary Insured.

Residence Address (No PO Box) **(REQUIRED)**

ADDRESS _____

CITY STATE ZIP CODE

Mailing Address (if different from Residence Address)

ADDRESS _____

CITY STATE ZIP CODE

Employer _____

Annual Income \$ _____

3. CHILDREN PROPOSED FOR COVERAGE

NAME (FIRST, MI, LAST)	SOCIAL SECURITY NO.	SEX		STATE OF BIRTH	DATE OF BIRTH MM / DD / YY
		M	F		
1.		<input type="radio"/>	<input type="radio"/>		
2.		<input type="radio"/>	<input type="radio"/>		
3.		<input type="radio"/>	<input type="radio"/>		
4.		<input type="radio"/>	<input type="radio"/>		
5.		<input type="radio"/>	<input type="radio"/>		

4. PRIMARY BENEFICIARY(IES)

NAME (FIRST, MI, LAST)	SOCIAL SECURITY/ TAX ID No.	SEX		DATE OF BIRTH MM / DD / YY	RELATIONSHIP TO PRIMARY INSURED	% ALLOCATED (MUST TOTAL 100%)
		M	F			
1.		<input type="radio"/>	<input type="radio"/>			_____ %
2.		<input type="radio"/>	<input type="radio"/>			_____ %
3.		<input type="radio"/>	<input type="radio"/>			_____ %
4.		<input type="radio"/>	<input type="radio"/>			_____ %

5. CONTINGENT BENEFICIARY(IES)

NAME (FIRST, MI, LAST)	SOCIAL SECURITY/ TAX ID No.	SEX		DATE OF BIRTH MM / DD / YY	RELATIONSHIP TO PRIMARY INSURED	% ALLOCATED (MUST TOTAL 100%)
		M	F			
1.		<input type="radio"/>	<input type="radio"/>			_____ %
2.		<input type="radio"/>	<input type="radio"/>			_____ %
3.		<input type="radio"/>	<input type="radio"/>			_____ %
4.		<input type="radio"/>	<input type="radio"/>			_____ %

6. PAYOR INFORMATION

Is the Proposed Primary Insured the Payor? Yes No (If "No", complete this section.)

Payor Name _____ *if same address as Proposed Primary Insured.*
FIRST MI LAST Residence Address (No PO Box) **(REQUIRED)**

Relationship to Proposed Primary Insured _____ ADDRESS _____

SSN/TIN _____ Date of Birth ____ / ____ / ____
MM DD YY CITY STATE ZIP CODE

Daytime Ph. () _____ Evening Ph. () _____ Mailing Address (if different from Residence Address)

Email Address _____ ADDRESS _____
CITY STATE ZIP CODE

7. OWNER INFORMATION

Is the Proposed Primary Insured the Owner? Yes No (If "No", complete this section.)

Owner Name _____ *if same address as Proposed Primary Insured.*
FIRST MI LAST Residence Address (No PO Box) **(REQUIRED)**

Relationship to Proposed Primary Insured _____
 Male Female ADDRESS _____

SSN/TIN _____ Date of Birth ____ / ____ / ____
MM DD YY CITY STATE ZIP CODE

Daytime Ph. () _____ Evening Ph. () _____ Mailing Address (if different from Residence Address)

Email Address _____ ADDRESS _____
CITY STATE ZIP CODE

8. PAYMENT INFORMATION

Liberty EasyPay® (Monthly) Direct Bill (Quarterly) Direct Bill (Semi-Annual) Direct Bill (Annual)

Worksite Other (Specify) _____

9. PLAN OF INSURANCE

WHOLE LIFE/LIFE PAID-UP at 65

\$ _____

FACE AMOUNT

Base Plan

- Whole Life
- Life Paid-Up at 65
- Other

Primary Insured

- Non-Tobacco
- Tobacco

Other Insured

- Non-Tobacco
- Tobacco

Optional Riders/Amounts Applied For (✓which apply)

- 10 Yr. 20 Yr. Level Term Insured
- 10 Yr. 20 Yr. Level Term Spouse
- Children's Insurance Rider
- Other (Specify) _____

FACE AMOUNT

\$ _____

\$ _____

\$ _____

\$ _____

Optional Benefits/Amounts Applied For (✓which apply)

- Waiver of Premium
- Accidental Death
- Accidental Death – Spouse
- Added Protection Guarantee
- Other (Specify) _____

\$ _____

\$ _____

\$ _____

\$ _____

TOTAL PREMIUM \$ _____

Is this policy rated? Yes No (If "Yes", indicate rating here.) _____

CANCER

- Individual
- Family

Optional Riders (Plans 886/887 only)

- Radiation/Chemotherapy Rider
 - A B C
- Additional Benefit Rider
- if being added to existing policy Policy # _____

TOTAL PREMIUM \$ _____

PART II

INFORMATION ON PROPOSED INSURED PERSON(S) NAMED IN PART I

Questions apply to all persons applying for coverage with this application. Provide details to all "Yes" responses in the Remarks Section on Page 6. Indicate question number and insured for each remark.

EXISTING COVERAGE

1. Do any Proposed Insureds have any existing life insurance or annuity contracts? Yes No
 (If "Yes", submit required replacement forms, provide details below and list sales material used.)

Insured Name	Company	Date of Issue (mm/yy)	Benefit Amount

List all sales material used in the sales presentation for the life insurance or annuity being applied for:

DESCRIPTION OF SALES MATERIAL USED	FORM NUMBER
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Primary Insured

2. In the past twelve months, have you used any form of tobacco or nicotine products? Yes No
3. Are you a citizen of the United States or Canada? Yes No
4. Do you have a Driver's License? Yes No
 (If "No", provide details.)
 License # _____
 State _____
5. Are you currently employed? Yes No
 (If "No", provide details.)
 Occupation _____
6. What is your current height and weight? Height _____ Weight _____
7. Do you have a personal physician? Yes No
 Physician's Name _____
 City/State _____
 Phone _____
 Date Last Seen and Treatment _____

Spouse/Other Insured

2. In the past twelve months, have you used any form of tobacco or nicotine products? Yes No
3. Are you a citizen of the United States or Canada? Yes No
4. Do you have a Driver's License? Yes No
 (If "No", provide details.)
 License # _____
 State _____
5. Are you currently employed? Yes No
 (If "No", provide details.)
 Occupation _____
6. What is your current height and weight? Height _____ Weight _____
7. Do you have a personal physician? Yes No
 Physician's Name _____
 City/State _____
 Phone _____
 Date Last Seen and Treatment _____

8. Information for children proposed for coverage:

	<u>Height</u>	<u>Weight</u>	<u>Physician's Name, City and State</u>	<u>Physician's Phone Number</u>
Child #1	_____	_____	_____	_____
Child #2	_____	_____	_____	_____
Child #3	_____	_____	_____	_____
Child #4	_____	_____	_____	_____
Child #5	_____	_____	_____	_____

9. a. Is any applicant proposed for coverage currently less than 6 years old? Yes No
 b. If "Yes", did the applicant(s) spend more than 7 days in the hospital at birth? Yes No

► IF APPLYING FOR CANCER COVERAGE ONLY – PROCEED TO QUESTION #13.

10. In the past 10 years, have you been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
11. In the past 10 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:
- a. high blood pressure, chest pain, heart attack, abnormal heart rhythm, heart murmur or heart valve disease, peripheral vascular disease, phlebitis, deep vein thrombosis or any other disease or disorder of the heart, blood vessels or circulatory system? Yes No
 - b. anemia, clotting or platelet disorder, or any other disease or disorder of the blood? Yes No
 - c. asthma, chronic bronchitis, emphysema, COPD, pneumonia, sleep apnea, shortness of breath, chronic cough or any other disease or disorder of the lung or respiratory system? Yes No
 - d. diabetes or any disease or disorder of the pituitary, thyroid, parathyroid, or adrenal glands? Yes No
 - e. epilepsy, seizures, tremors, stroke, paralysis, head injury, memory loss, Alzheimer’s disease, dementia, or any other disease or disorder of the brain or nervous system? Yes No
 - f. dizziness or any disease or disorder of the eyes, ears, nose or throat? Yes No
 - g. arthritis, lupus, chronic fatigue syndrome, fibromyalgia, neuropathy or any disease or disorder of the muscles, connective tissues, nerves, bones, back or joints? Yes No
 - h. anxiety, depression, suicidal attempts or thoughts, schizophrenia, bipolar disorder, attention deficit disorders (ADD and ADHD), mental deficiency, or any other mental or nervous disorder? Yes No
 - i. hepatitis, or any disease or disorder of the esophagus, stomach, pancreas, liver, intestines, colon, rectum or other abdominal organs? Yes No
 - j. sexually transmitted disease or any disease or disorder of the gynecologic or reproductive system? Yes No
 - k. disease or disorder of the kidney, bladder, prostate or any other disease or disorder of the genito-urinary system? Yes No
12. In the past 5 years, have you:
- a. had surgery, been seen in an emergency room, or been admitted to any medical facility? Yes No
 - b. been advised to have any consultation, evaluation, test, surgery, or hospitalization which has not yet been completed? Yes No
13. In the past 10 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:
- a. Hodgkin’s disease, leukemia, lymphoma, tumor or any other form of cancer or malignancy? Yes No
 - b. cyst, polyp, lump, or other growth, or any disease or disorder of the breast, skin, or lymph nodes? Yes No
14. Have you been advised to take or are you currently taking any prescription medications, injections, over the counter medications or herbal remedies that you have not already told us about in a previous question? Yes No
15. Are you currently covered under Medicaid? Yes No
16. Have you ever had an application for life, accident, health or disability insurance rated, postponed or declined? Yes No

► IF APPLYING FOR CANCER COVERAGE ONLY – PROCEED TO ACKNOWLEDGMENT.

The following questions apply only to Proposed Insureds who are age 16 or older:

(If “Yes”, provide complete details in the Remarks Section on Page 6.)

17. In the past 5 years, have you:
- a. been charged with DUI/DWI, had 2 or more moving violations, had an accident, or had your driver’s license suspended or revoked? Yes No
 - b. flown as a pilot, student pilot or crew member of any aircraft or have any intentions to do so? Yes No
 - c. engaged in parachuting, skydiving, scuba diving below 50 feet, racing of any motor powered land vehicle or watercraft, or any other hazardous activities or extreme sports or have any intentions to do so? Yes No
18. Have you ever been arrested for, convicted of, or plead guilty or “no contest” to possession or distribution of drugs or to any felony? Yes No
19. In the past 5 years, have you:
- a. used cocaine, crack, heroin, methamphetamine or any other illegal substance? Yes No
 - b. used any controlled substances or prescription drugs, except as prescribed to you by a healthcare professional licensed to prescribe controlled substances? Yes No
 - c. been advised by a healthcare professional to receive treatment or counseling for alcohol or drug use? Yes No
 - d. been advised by a healthcare professional to reduce or stop alcohol or drug use? Yes No
 - e. been a member of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)? Yes No
20. In the past 5 years, have you received Worker’s Compensation, Social Security disability benefits, or any other long term disability payments? Yes No

REMARKS

ACKNOWLEDGMENT

By signing below, each person applying for coverage understands, 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. No insurance will take effect under this application unless and until all of the following conditions have occurred while all persons proposed for coverage are alive and the health and all other conditions affecting the insurability of those persons remain as stated in the application: (1) all medical examinations, tests, x-rays, electrocardiograms, and medical questionnaires required by the rules and standards followed by the Company have been completed; and (2) as of the date and time those requirements are completed, each person proposed for coverage is insurable under the rules and standards followed by the Company for the plan, rating class, premium rate, and amount of insurance applied for; and (3) the first full modal premium paid. No agent or person other than the Company's Home Office officers has the authority to change or modify this application or the policy applied for.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care provider, pharmacy benefit manager, insurance company or reinsurer, government agency, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer or other organization, institution or person to disclose to the insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers of Liberty Life Insurance Company (the "Company"), the following information pertaining to me or any of my minor children proposed for coverage: (1) employment information; (2) other insurance coverage and claims; (3) prescribed drugs; (4) past and present physical, mental, drug and/or alcohol conditions; (5) motor vehicle records; (6) avocations; (7) general reputation; and (8) other personal characteristics. I understand and agree that the Company may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits and that the Company may disclose all or some of my information to its insurance administrators, its reinsurance companies, its agents, the MIB, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months. A photographic copy of this authorization is as valid as the original and I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation may cause the Company to reject my application.

Accelerated Benefit Disclosure - By signing below, I acknowledge that I have received and read, if applicable, the Accelerated Benefit Disclosure Statement.

Dated and Signed at _____ on _____ 20____
City and State Month Day

X _____
Signature of Proposed Primary Insured
(Parent or Legal Guardian if Proposed Insured is under the age of 18)

X _____
Signature of Proposed Spouse or Other Insured
(if applicable)

X _____
Signature of Owner or Applicant
(if other than Proposed Primary Insured)

Agent's Statement: I have personally verified the identity of the proposed Owner listed in this application by reviewing a government issued ID for a proposed individual Owner and documents that confirm the legal entity status of a proposed non-natural Owner, such as a business or trust.

To the best of my knowledge, the Proposed Insured(s) does does not have any existing life insurance or annuity contracts.

If there is existing insurance, replacement forms must be completed and signed.

Printed Name of Writing Agent (Required)

X _____
Signature of Writing Agent (as Witness)

Proposed Owner Name (Required)

X _____
Signature of Producer (Required)

ID/Document Name (Required)

ID Number (Required)

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.

WRITING AGENT INFORMATION

Agent/Representative's Printed Name _____

Email Address _____

Phone Number (_____) _____

Fax Number (_____) _____

Agency Office/Broker-Dealer Name _____

Agent Account/Broker No. _____

Agency Office/Broker-Dealer Address _____

CONTACT INFORMATION

Status updates and requests for additional information should be sent to:

Agent E-mail Address _____

Name _____ E-mail _____

Commissions Split: _____ % Agent _____

_____ % Agent _____

Remarks _____

HOME OFFICE AMENDMENT(S)

(NOT APPLICABLE IN PENNSYLVANIA AND WEST VIRGINIA)

Application for Level Term Life Insurance

LIBERTY LIFE INSURANCE COMPANY, Greenville, SC

1. PROPOSED PRIMARY INSURED INFORMATION

Name _____ Daytime Phone () _____
FIRST MI LAST

SSN _____ Male Female Evening Phone () _____

Marital Status Married Single Sep. Div. Widowed Do you have a Driver's License? Yes No

State of Birth _____ Date of Birth / / License # _____ State _____
MM DD YYYY

Height _____ Weight _____ If "No", provide details. _____

Residence Address (No PO Box) **(REQUIRED)** Are you a Citizen of the United States or Canada? Yes No
 _____ If "No", provide details. _____
ADDRESS

_____ Are you currently employed? Yes No
CITY STATE ZIP CODE If "Yes", what is your occupation? _____

Mailing Address (if different from Residence Address) If "Yes", please provide Annual Income. \$ _____
 _____ If "No", please explain. _____
ADDRESS

_____ If "No", please provide Household Income. \$ _____
CITY STATE ZIP CODE

Email Address _____

2. PLAN OF INSURANCE

<p>FACE AMOUNT \$ _____</p> <p>LEVEL TERM BASE PLAN <input type="radio"/> 10 Yr. <input type="radio"/> 15 Yr. <input type="radio"/> 20 Yr. <input type="radio"/> 30 Yr.</p> <p>PREMIUM RATE CLASS APPLIED FOR</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"><u>NON-TOBACCO</u></td> <td style="width: 50%;"><u>TOBACCO</u></td> </tr> <tr> <td><input type="radio"/> Preferred Plus</td> <td><input type="radio"/> Preferred</td> </tr> <tr> <td><input type="radio"/> Preferred</td> <td><input type="radio"/> Standard Plus</td> </tr> <tr> <td><input type="radio"/> Standard</td> <td><input type="radio"/> Standard</td> </tr> </table>	<u>NON-TOBACCO</u>	<u>TOBACCO</u>	<input type="radio"/> Preferred Plus	<input type="radio"/> Preferred	<input type="radio"/> Preferred	<input type="radio"/> Standard Plus	<input type="radio"/> Standard	<input type="radio"/> Standard	<p>CHECK (✓) WHICH APPLY. FACE AMOUNT</p> <p>OPTIONAL RIDERS</p> <p><input type="radio"/> Child's Rider \$ _____</p> <p><input type="radio"/> Other _____ \$ _____</p> <p>OPTIONAL BENEFITS</p> <p><input type="radio"/> Accidental Death \$ _____</p> <p><input type="radio"/> Waiver of Premium</p>
<u>NON-TOBACCO</u>	<u>TOBACCO</u>								
<input type="radio"/> Preferred Plus	<input type="radio"/> Preferred								
<input type="radio"/> Preferred	<input type="radio"/> Standard Plus								
<input type="radio"/> Standard	<input type="radio"/> Standard								

3. PRIMARY BENEFICIARY(IES)

NAME (FIRST, MI, LAST)	SOCIAL SECURITY/ TAX ID No.	SEX	DATE OF BIRTH	RELATIONSHIP TO PRIMARY INSURED	% ALLOCATED (MUST TOTAL 100%)
		M F	MM / DD / YYYY		
1.		<input type="radio"/> <input type="radio"/>			_____ %
2.		<input type="radio"/> <input type="radio"/>			_____ %
3.		<input type="radio"/> <input type="radio"/>			_____ %

4. CONTINGENT BENEFICIARY(IES)

NAME (FIRST, MI, LAST)	SOCIAL SECURITY/ TAX ID No.	SEX	DATE OF BIRTH	RELATIONSHIP TO PRIMARY INSURED	% ALLOCATED (MUST TOTAL 100%)
		M F	MM / DD / YYYY		
1.		<input type="radio"/> <input type="radio"/>			_____ %
2.		<input type="radio"/> <input type="radio"/>			_____ %
3.		<input type="radio"/> <input type="radio"/>			_____ %

Applicant Name _____
FIRST MI LAST

5. PAYOR INFORMATION

Is the Proposed Primary Insured the Payor? Yes No
(If "No", complete this section.)

Payor Name _____
FIRST MI LAST

Relationship to Applicant _____

SSN/TIN _____ Date of Birth / /
MM DD YYYY

Daytime Phone () _____

Evening Phone () _____

Residence Address (PO Box not allowed) **(REQUIRED)**

_____ ADDRESS
CITY STATE ZIP CODE

Mailing Address *(if different from Residence Address)*

_____ ADDRESS
CITY STATE ZIP CODE

Email Address _____

6. OWNER INFORMATION

Is the Proposed Primary Insured the Owner? Yes No
(If "No", complete this section.)

Owner Name _____
FIRST MI LAST

Relationship to Applicant _____ Male Female

SSN/TIN _____ Date of Birth / /
MM DD YYYY

Daytime Phone () _____

Evening Phone () _____

Residence Address (PO Box not allowed) **(REQUIRED)**

_____ ADDRESS
CITY STATE ZIP CODE

Mailing Address *(if different from Residence Address)*

_____ ADDRESS
CITY STATE ZIP CODE

Email Address _____

7. CHILDREN PROPOSED FOR COVERAGE

NAME (FIRST, MI, LAST)	SSN	SEX		HEIGHT	WEIGHT	STATE OF BIRTH	DATE OF BIRTH MM / DD / YYYY
		M	F				
1.		<input type="radio"/>	<input type="radio"/>				
2.		<input type="radio"/>	<input type="radio"/>				
3.		<input type="radio"/>	<input type="radio"/>				

8. PAYMENT INFORMATION

SELECT ONE (1) BILLING METHOD:

Monthly Bank Draft (EFT)
(Please complete EFT authorization form.)

Direct Billing *(Select frequency.)* Payroll Deduction
 Quarterly *(Worksite Only)*
 Semi-Annual
 Annual

TOTAL MODAL PREMIUM \$ _____

SELECT PAYMENT METHOD FOR INITIAL PREMIUM:

Check

Credit Card (Initial Premium only)
(Complete Credit Card Authorization form.)

Electronic Funds Transfer
(Complete EFT Authorization form.)

AMOUNT SUBMITTED WITH APPLICATION \$ _____

9. EXISTING COVERAGE

a. Does any Proposed Insured have existing life insurance or annuity contracts? Yes No
(If "Yes", submit required replacement forms and provide details below.)

Insured Name	Company	Date of Issue (mm/yy)	Benefit Amount

Applicant Name _____
FIRST MI LAST

10. PHYSICIAN INFORMATION

Proposed Primary Insured's Personal Physician: Name _____ Does not have a physician

City _____ State _____ Phone (_____) _____

Children's Personal Physician: Name _____ Does not have a physician

City _____ State _____ Phone (_____) _____

11. GENERAL QUESTIONS

Questions apply to all persons applying for coverage with this application. Provide details to all "Yes" responses in the Details Section. Indicate question number and insured for each remark.

Details to "Yes" Answers

1. In the past 10 years, have you been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No
2. In the past 10 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, lung, kidney, pancreas, liver, colon, brain or nervous system; diabetes; stroke; or cancer? Yes No
3. In the past 5 years, have you been advised to have any consultation, evaluation, test, surgery, or hospitalization which has not yet been completed? Yes No
4. In the past twelve months, have you used any form of tobacco or nicotine products? Yes No
(If "Yes", indicate type, date last used, and quantity per day.)
5. In the past 5 years, have you
 - (a) been charged with DUI/DWI, had 2 or more moving violations, had an accident, or had your driver's license suspended or revoked? Yes No
 - (b) flown as pilot, student pilot or crew member of any aircraft or have any intentions to do so? Yes No
 - (c) engaged in parachuting, skydiving, scuba diving below 50 feet, racing of any motor powered land vehicle or watercraft, or any other hazardous activities or extreme sports or have any intentions to do so? Yes No
6. Have you ever been arrested for, convicted of, or plead guilty or "no contest" to possession or distribution of drugs or to any felony? Yes No
(If "Yes", please include charge, date and location of arrest.)
7. Do you have plans to travel or reside outside of the United States or Canada in the next 12 months? Yes No
(If "Yes", please provide date(s) and location(s).)
8. Have you ever had an application for life, accident, health, or disability insurance rated, postponed or declined? Yes No
(If "Yes", provide details.)
9. Do you currently have an application or informal inquiry for life insurance pending with any company? Yes No

Applicant Name _____
FIRST MI LAST

ACKNOWLEDGMENT

By signing below, each person applying for coverage understands, represents, and agrees that:

The statements and answers made in this application are true and complete and are made to obtain the insurance applied for. No insurance shall take effect under this application unless and until all of the following conditions have occurred while the Proposed Insured(s) is/are alive and the health and all other conditions affecting the insurability of such person(s) remain as stated in the application: (1) all medical examinations, tests, x-rays, electrocardiograms, and medical questionnaires required by the rules and standards followed by Liberty Life Insurance Company (the "Company") have been completed; and (2) as of the date and time those requirements are completed, each Proposed Insured is insurable under the rules and standards followed by the Company for the plan, rating class, premium rate, and amount of insurance applied for; and (3) the first full initial premium has been paid. No one except Company 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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care provider, pharmacy benefit manager, insurance company or reinsurer, government agency, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer or other organization, institution or person to disclose to the insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers of Liberty Life Insurance Company (the "Company"), the following information pertaining to me or any of my minor children proposed for coverage: (1) employment information; (2) other insurance coverage and claims; (3) prescribed drugs; (4) past and present physical, mental, drug and/or alcohol conditions; (5) motor vehicle records; (6) avocations; (7) general reputation; and (8) other personal characteristics. I understand and agree that the Company may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits and that the Company may disclose all or some of my information to its insurance administrators, its reinsurance companies, its agents, the MIB, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months. A photographic copy of this authorization is as valid as the original and I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation may cause the Company to reject my application.

Accelerated Benefit Disclosure - By signing below, I acknowledge that I have received and read, if applicable, the Accelerated Benefit Disclosure Statement.

Dated and Signed at _____ on _____ 20____
City and State Month Day

X _____
Signature of Proposed Primary Insured
(Parent or Legal Guardian if Proposed Insured
is under the age of 18)

X _____
Signature of Owner or Applicant
(if other than Proposed Primary Insured)

Agent's Statement: I have truly and accurately recorded the information given by the Proposed Insured(s) or Applicant.
To the best of my knowledge, the Proposed Insured(s) does does not have any existing life insurance or annuity contracts.

Printed Name of Writing Agent (Required)

X _____
Signature of Writing Agent (as Witness)

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.

Applicant Name _____
FIRST MI LAST

WRITING AGENT INFORMATION

Agent/Representative's Printed Name _____

Email Address _____

Phone Number (_____) _____

Fax Number (_____) _____

Agency Office/Broker-Dealer Name _____

Agent Account/Broker No. _____

Agency Office/Broker-Dealer Address _____

Key Contact Email Address _____

Key Contact Phone Number _____

Remarks _____

Is this a Companion Policy? Yes No

Name on Associated Application _____

HOME OFFICE AMENDMENT(S)

(Not applicable in New Hampshire, Pennsylvania and West Virginia)

4. Tell Us About the Proposed Premium Payment Plan

Billing Frequency and Method: Annual Direct Bill Semi-Annual Direct Bill Salary Savings Monthly Bank Draft (EFT)
 Planned Premium \$ _____ Initial Payment (Payable to Liberty Life Insurance Company) \$ _____

5. Tell Us About the Proposed Other Insured

Name (First, Middle, Last) _____ Male Female
 Date of Birth ____/____/____ State of Birth ____ Marital Status: Married Single Separated Divorced Widowed
 Height (ft/in) _____ Weight (lbs) _____ SSN/Tax ID _____ E-mail _____
 Residence (No PO Box) _____ Mailing Address (if different) _____
 City _____ State _____ Zip _____ City _____ State _____ Zip _____
 Daytime Phone (____) _____ Evening (____) _____ Best time to call: 8am – Noon Noon – 5pm 5pm – 9pm
 Are you a citizen of the United States? Yes No If "no", provide details _____
 Do you have a driver's license? Yes License Number _____ State of Issue _____
 No If "no", provide details _____
 Are you employed? Yes Occupation/Duties _____ Annual Income \$ _____
 No If "no", provide details _____
 Have you ever used any tobacco or nicotine products? Yes No
 If "yes", when did you last use tobacco or nicotine products (mm/yyyy) _____ Type _____ Quantity _____
 Premium Class Requested: Preferred Plus Preferred Non Tobacco Non Tobacco Preferred Tobacco Tobacco Juvenile
 Relationship to Proposed Primary Insured _____ Other Insured Rider Benefit Amount \$ _____
 Additional Benefits & Riders: Other Insured Accidental Death Benefit \$ _____

Beneficiary Information for Other Insured Rider (If unanswered, Proposed Primary Insured will be Beneficiary.)

Name	Social Security/ Tax ID Number	Date of Birth mm/dd/yyyy	Relationship to Other Insured	Primary or Contingent	Percent Allocated

If proposed Beneficiary is a non-natural entity, complete the following questions: Date of Trust _____
 Trustee _____ State or country of formation _____

6. Tell Us About Your Children Proposed for Coverage

Name (First, Middle, Last)	M/F	Social Security Number	Date of Birth mm/dd/yyyy	State of Birth	Height	Weight

7. Tell Us About the Proposed Owner of Your Policy (If unanswered, Primary Insured will be Owner.)Proposed Owner is: Proposed Primary Insured Other - If "Other", complete questions below.

Name _____ Relationship to Proposed Insured _____

Date of Birth ____/____/____ SSN/Tax ID _____ Phone (____) _____

Address (No PO Box) _____ Mailing Address (if different) _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

If proposed Owner is a non-natural entity, complete the following questions: Date of Trust _____

Trustee _____ State or country of formation _____

8. Tell Us About the Proposed Premium Payor of Your Policy (If unanswered, Policy Owner will be Payor.)Proposed Premium Payor is: Proposed Policy Owner Proposed Primary Insured Other - If "Other", complete questions below.

Name _____ Relationship to Proposed Insured _____

Date of Birth ____/____/____ SSN/Tax ID _____ Phone (____) _____

Address (No PO Box) _____ Mailing Address (if different) _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

If proposed Premium Payor is a non-natural entity, complete the following questions: Date of Trust _____

Trustee _____ State or country of formation _____

9. Tell Us About Existing Life Insurance on any Proposed InsuredDo any Proposed Insureds have existing life insurance? Yes NoIf "yes", provide details below **and submit required replacement forms.**

Insured Name	Company	Date of Issue (mm/yyyy)	Benefit Amount

10. Tell Us About the Personal Physician for All Proposed InsuredsProposed Primary Insured's Personal Physician: Name _____ Does not have a physician

City _____ State _____ Phone (____) _____

Other Insured's Personal Physician: Name _____ Does not have a physician

City _____ State _____ Phone (____) _____

Children's Personal Physician: Name _____ Does not have a physician

City _____ State _____ Phone (____) _____

11. Tell Us About All Proposed Insureds

Complete the following questions for all Proposed Insureds, including the Proposed Primary Insured, Proposed Other Insured and each child to be covered under the Children's Insurance Benefit Rider. Explain all "Yes" responses in the Remarks Section. Indicate question number and insured for each remark.

	Yes	No	Remarks
A. In the past ten years, has any Proposed Insured 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, lung, kidney, liver, brain, or nervous system; diabetes; stroke; or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
B. Has any Proposed Insured been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of his or her immune system, or had a positive HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
C. In the past five years, has any Proposed Insured engaged in any of the following or does any Proposed Insured intend to do so:			
i. Flying as a pilot, student pilot, or crew member?	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Ballooning, parachuting, hang gliding, skydiving, vehicle racing, scuba diving below 50 feet, mountain climbing, or any other similar avocation?	<input type="checkbox"/>	<input type="checkbox"/>	
D. In the past five years, has any Proposed Insured had a driver's license suspended or revoked, been charged with a DUI/DWI, had two or more moving violations, or had an accident while operating a motor vehicle?	<input type="checkbox"/>	<input type="checkbox"/>	
E. Has any Proposed Insured ever been arrested for, convicted of, or plead "guilty" or "no contest" to any felony?	<input type="checkbox"/>	<input type="checkbox"/>	
F. In the past 12 months, has any Proposed Insured traveled outside of the United States or Canada, or does any Proposed Insured have plans to do so in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
G. Has any Proposed Insured applying for coverage ever had a life, accident or health insurance application rated, declined or withdrawn by Liberty Life Insurance Company or any other company?	<input type="checkbox"/>	<input type="checkbox"/>	
H. Does any Proposed Insured have an application or informal inquiry for life insurance pending with any other company or society, or has any Proposed Insured ever withdrawn such application or informal inquiry?	<input type="checkbox"/>	<input type="checkbox"/>	

12. Home Office Amendments

13. Authorizations, Declarations & Signatures

Authorization to Obtain and Disclose Information - I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care provider, pharmacy benefit manager, insurance company or reinsurer, government agency, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer or other organization, institution or person to disclose to the insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers of Liberty Life Insurance Company (the "Company"), the following information pertaining to me or any of my minor children proposed for coverage: (1) employment information; (2) other insurance coverage; (3) prescribed drugs; (4) past and present physical, mental, drug and/or alcohol conditions; (5) motor vehicle records; (6) avocations; (7) general reputation; and (8) other personal characteristics.

I understand and agree to the following:

The Company may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits. The Company may disclose all or some of my information to its insurance administrators, its reinsurance companies, its agents, the MIB, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months. A photographic copy of this authorization is as valid as the original and I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation may cause the Company to reject my application.

Acknowledgement - By signing below, each person applying for coverage understands, 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. Except as provided by the Conditional Receipt, no insurance will take effect under this application unless and until all of the following conditions have occurred: (1) the Company has issued the policy as applied for; (2) at least the first two minimum monthly premiums have been paid; and (3) at the time of issue and payment, all persons proposed for insurance are alive and the health and all other conditions affecting the insurability of those person or persons remain as stated in all parts of the application. No agent or person other than the Company's Home Office officers has the authority to change or modify this application or the policy applied for.

Accelerated Benefit Disclosure - By signing below, I acknowledge that I have received and read the Accelerated Benefit Disclosure Statement.

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.

All completed materials must be sent to our Service Center:
RBC Insurance, PO Box 725449, Atlanta, GA 31139 or fax (770) 690-1985.

Application Signed At: City _____ State _____

X Signature of Proposed Insured _____ Date _____

X Signature of Proposed Other Insured _____ Date _____

X Signature of Proposed Owner _____ Date _____



OTHER INSURED RIDER SUPPLEMENT

Liberty Life Insurance Company
Greenville, SC

1. Tell Us About the Policy Adding this Coverage

Proposed Primary Insured (First, Middle, Last)

2. Tell Us About the Proposed Other Insured

Name (First, Middle, Last) Male Female

Date of Birth State of Birth Marital Status: Married Single Separated Divorced Widowed

Height (ft/in) Weight (lbs) SSN/Tax ID E-mail

Residence (No PO Box) Mailing Address (if different)

City State Zip City State Zip

Daytime Phone Evening Best time to call: 8am - Noon Noon - 5pm 5pm - 9pm

Are you a citizen of the United States? Yes No If "no", provide details

Do you have a driver's license? Yes License Number State of Issue No If "no", provide details

Are you employed? Yes Occupation/Duties Annual Income \$ No If "no", provide details

Have you ever used any tobacco or nicotine products? Yes No If "yes", when did you last use tobacco or nicotine products (mm/yyyy) Type Quantity

Premium Class Requested: Preferred Plus Preferred Non Tobacco Non Tobacco Preferred Tobacco Tobacco Juvenile

Relationship to Proposed Primary Insured Other Insured Rider Benefit Amount \$

Additional Benefits & Riders: Other Insured Accidental Death Benefit \$

Beneficiary Information for Other Insured Rider (If unanswered, Proposed Primary Insured will be Beneficiary.)

Table with 6 columns: Name, Social Security/Tax ID Number, Date of Birth mm/dd/yyyy, Relationship to Other Insured, Primary or Contingent, Percent Allocated

If proposed Beneficiary is a non-natural entity, complete the following questions: Date of Trust Trustee State or country of formation

3. Tell Us About Existing Life Insurance on any Proposed Other Insured

Do you have any existing life insurance? Yes No If "yes", provide details below and submit required replacement forms.

Table with 4 columns: Insured Name, Company, Date of Issue (mm/yyyy), Benefit Amount

4. Tell Us About Your Personal Physician

Other Insured's Personal Physician: Name _____ Does not have a physician
 City _____ State _____ Phone (____) _____

5. Tell Us About the Proposed Other Insured

Complete the following questions for the Proposed Other Insured. Explain all "Yes" responses in the Remarks Section. Indicate question number and insured for each remark.

	Yes	No	Remarks
A. In the past ten years, has any Proposed Other Insured 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, lung, kidney, liver, brain, or nervous system; diabetes; stroke; or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
B. Has any Proposed Other Insured been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of his or her immune system, or had a positive HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	
C. In the past five years, has any Proposed Other Insured engaged in any of the following or does any Proposed Other Insured intend to do so:			
i. Flying as a pilot, student pilot, or crew member?	<input type="checkbox"/>	<input type="checkbox"/>	
ii. Ballooning, parachuting, hang gliding, skydiving, vehicle racing, scuba diving below 50 feet, mountain climbing, or any other similar avocation?	<input type="checkbox"/>	<input type="checkbox"/>	
D. In the past five years, has any Proposed Other Insured had a driver's license suspended or revoked, been charged with a DUI/DWI, had two or more moving violations, or had an accident while operating a motor vehicle?	<input type="checkbox"/>	<input type="checkbox"/>	
E. Has any Proposed Other Insured ever been arrested for, convicted of, or plead "guilty" or "no contest" to any felony?	<input type="checkbox"/>	<input type="checkbox"/>	
F. In the past 12 months, has any Proposed Other Insured traveled outside of the United States or Canada, or does any Proposed Other Insured have plans to do so in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
G. Has any Proposed Other Insured applying for coverage ever had a life, accident or health insurance application rated, declined or withdrawn by Liberty Life Insurance Company or any other company?	<input type="checkbox"/>	<input type="checkbox"/>	
H. Does any Proposed Other Insured have an application or informal inquiry for life insurance pending with any other company or society, or has any Proposed Other Insured ever withdrawn such application or informal inquiry?	<input type="checkbox"/>	<input type="checkbox"/>	

6. Authorizations, Declarations & Signatures

Authorization to Obtain and Disclose Information - I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care provider, pharmacy benefit manager, insurance company or reinsurer, government agency, the Medical Information Bureau, Inc. (the "MIB"), consumer reporting agency, employer or other organization, institution or person to disclose to the insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers of Liberty Life Insurance Company (the "Company"), the following information pertaining to me or any of my minor children proposed for coverage: (1) employment information; (2) other insurance coverage; (3) prescribed drugs; (4) past and present physical, mental, drug and/or alcohol conditions; (5) motor vehicle records; (6) avocations; (7) general reputation; and (8) other personal characteristics.

I understand and agree to the following:

The Company may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits. The Company may disclose all or some of my information to its insurance administrators, its reinsurance companies, its agents, the MIB, and other persons or organizations performing business or legal services in connection with my application. This authorization is valid for 24 months. A photographic copy of this authorization is as valid as the original and I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. However, that revocation may cause the Company to reject my application.

Acknowledgement - By signing below, each person applying for coverage understands, 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. Except as provided by the Conditional Receipt, no insurance will take effect under this application unless and until all of the following conditions have occurred: (1) the Company has issued the policy as applied for; (2) at least the first two minimum monthly premiums have been paid; and (3) at the time of issue and payment, all persons proposed for insurance are alive and the health and all other conditions affecting the insurability of those person or persons remain as stated in all parts of the application. No agent or person other than the Company's Home Office officers has the authority to change or modify this application or the policy applied for.

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.

All completed materials must be sent to our Service Center:
RBC Insurance, PO Box 725449, Atlanta, GA 31139 or fax (770) 690-1985.

Application Signed At: City _____ State _____

X Signature of Proposed Other Insured _____ Date _____

X Signature of Proposed Owner _____ Date _____

7. Agent Statement and Signature

The Proposed Other Insured(s) has existing life insurance or annuity contracts? Yes No

The Proposed Other Insured(s) will be replacing an existing life insurance policy and/or annuity contract? Yes No
If "yes", please complete required replacement forms.

X Signature of Writing Agent _____ Date _____

Printed Name of Writing Agent (Required) _____

SERFF Tracking Number: LBLI-126152787 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 42426
Company Tracking Number: ET-APP ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NAIC model replacement update
Project Name/Number: ET-APP et al/ET-APP et al

Supporting Document Schedules

	Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	
Bypass Reason:	Not applicable. Filing to update replacement question due to your state's adoption of the NAIC Model replacement obligation.	
Comments:		

	Item Status:	Status Date:
Bypassed - Item:	Application	
Bypass Reason:	Not applicable. Filing to update replacement question due to your state's adoption of the NAIC Model replacement obligation.	
Comments:		