

SERFF Tracking Number: LBLI-126793451 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 46769
Company Tracking Number: LTR3006TIB(06-10)
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Apps and TIB rider
Project Name/Number: /

Filing at a Glance

Company: Liberty Life Insurance Company

Product Name: Apps and TIB rider

TOI: L04I Individual Life - Term

Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Filing Type: Form

SERFF Tr Num: LBLI-126793451

State: Arkansas

SERFF Status: Closed-Approved-
Closed

State Tr Num: 46769

Co Tr Num: LTR3006TIB(06-10)

State Status: Approved-Closed

Author: Julie Duncan

Reviewer(s): Linda Bird

Date Submitted: 09/13/2010

Disposition Date: 09/16/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

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:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 09/16/2010

Explanation for Other Group Market Type:

State Status Changed: 09/16/2010

Deemer Date:

Created By: Julie Duncan

Submitted By: Julie Duncan

Corresponding Filing Tracking Number:

Filing Description:

Form No. LTR3006TIB(06-10), Accelerated Death Benefit

LTA3009NSN(01-11), Application for Insurance

LTA3010NUN(01-11), Application for Insurance

Liberty Life Insurance Company has prepared the above referenced filing for your review and approval.

Form number LTR3006TIB(06-10) is an Accelerated Death Benefit Amendment. The benefit is inherent in the policy to

| | | | |
|---------------------------------|---------------------------------------|-------------------------------|---|
| <i>SERFF Tracking Number:</i> | <i>LBLI-126793451</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>Liberty Life Insurance Company</i> | <i>State Tracking Number:</i> | <i>46769</i> |
| <i>Company Tracking Number:</i> | <i>LTR3006TIB(06-10)</i> | | |
| <i>TOI:</i> | <i>L04I Individual Life - Term</i> | <i>Sub-TOI:</i> | <i>L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium</i> |
| <i>Product Name:</i> | <i>Apps and TIB rider</i> | | |
| <i>Project Name/Number:</i> | <i>/</i> | | |

which it is attached with no associated premium. The benefit provides a payment up to 75% of the face amount (subject to a maximum of \$300,000) upon receipt of proof by a certified physician that the insured is diagnosed to die within six months. The death benefit of the policy will be reduced by the amount of the accelerated benefit paid. In addition to being issued with new policies; this amendment will be added to and made a part of policies that are already in force since there is no associated premium for this coverage. A specimen copy of the required statement that will be provided to the Owner when a request is made for the Accelerated Death Benefit is also attached.

The Accelerated Death Benefit Amendment will be used with the following previously approved policy form numbers:

| Form number | Approval |
|-------------------|----------|
| LTP3000NSI(06-09) | 8-03-09 |
| LTP3001NUW(06-09) | 11-18-09 |
| LTP3002NSR(10-09) | 11-18-09 |
| LTP3003NUR(10-09) | 12-01-09 |

Form number LTA3009NSN(01-11) is the application to be used with previously approved policy form numbers LTP3000NSI(06-09) and LTP3002NSR(10-09). We are providing a John Doe, bracketed version to illustrate how the form may be completed during the sales process. All bracketed sections should be considered variable. A Statement of Variability is also attached.

Form number LTA3010NUN(01-11) is the application to be used with previously approved policy form numbers LTP3001NUW(06-09) and LTP3003NUR(10-09). We are providing a John Doe, bracketed version to illustrate how the form may be completed during the sales process. All bracketed sections should be considered variable. A Statement of Variability is also attached.

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.

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-126793451 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 46769
Company Tracking Number: LTR3006TIB(06-10)
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Product Name: Apps and TIB rider

Project Name/Number: /

Greenville, SC 29602
(864) 609-1172 ext. [Phone]

Group Name:
FEIN Number: 44-0188050

State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: \$150.00
Retaliatory? No
Fee Explanation:
Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--------------------------------|----------|----------------|---------------|
| Liberty Life Insurance Company | \$150.00 | 09/13/2010 | 39461338 |

SERFF Tracking Number: LBLI-126793451 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 46769
Company Tracking Number: LTR3006TIB(06-10)
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Apps and TIB rider
Project Name/Number: /

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|---------------------|------------|------------|----------------|
| Approved- Closed | Linda Bird | 09/16/2010 | 09/16/2010 |

SERFF Tracking Number: LBLI-126793451 State: Arkansas
Filing Company: Liberty Life Insurance Company State Tracking Number: 46769
Company Tracking Number: LTR3006TIB(06-10)
TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Apps and TIB rider
Project Name/Number: /

Disposition

Disposition Date: 09/16/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: LBLI-126793451 State: Arkansas
 Filing Company: Liberty Life Insurance Company State Tracking Number: 46769
 Company Tracking Number: LTR3006TIB(06-10)
 TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
 Fixed/Indeterminate Premium

Product Name: Apps and TIB rider

Project Name/Number: /

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|--|----------------------|---------------|
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | Application | | No |
| Supporting Document | Life & Annuity - Acturial Memo | | No |
| Supporting Document | Accelerated Death Benefit Disclosure Stmnt and Claim Disclosure | | Yes |
| Supporting Document | Statements of Variability | | Yes |
| Form | Amendment | | Yes |
| Form | Simplified Issue Individual Term life Insurance Application | | Yes |
| Form | Individual Term Life Insurance Application | | Yes |

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 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: Apps and TIB rider
 Project Name/Number: /

Form Schedule

Lead Form Number: LTR3006TIB(06-10)

| Schedule Item Status | Form Number | Form Type Form Name | Action | Action Specific Data | Readability | Attachment |
|----------------------|-------------------|---|---------|----------------------|-------------|-----------------------------------|
| | LTR3006TIB(06-10) | Policy/Cont Amendment ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | Initial | | 52.000 | LTR3006TIB(06-10).pdf |
| | LTA3009NSN(01-11) | Application/Simplified Issue Enrollment Individual Term life Form Insurance Application | Initial | | 50.400 | LTA3009NSN(01-11)-doe-bracket.pdf |
| | LTA3010NUN(01-11) | Application/Individual Term Life Enrollment Insurance Application Form | Initial | | 50.100 | LTA3010NUN(01-11)doe-bracket.pdf |

Liberty Life Insurance Company

Home Office: 2000 Wade Hampton Boulevard Greenville, SC 29615

Mailing Address: PO Box 19084 Greenville, SC 29602-9084

AMENDMENT

attached to and made a part of the Policy

Accelerated Death Benefit For Terminal Illness

The Accelerated Death Benefit Paid Under This Policy May Be Taxable. If So, The Owner May Incur A Tax Obligation. As With All Tax Matters, The Owner Should Seek Additional Information From His Personal Tax Advisor About The Tax Status Of The Accelerated Death Benefit Payment.

The Death Benefit And, If Applicable, Cash Values And Loan Values Will Be Reduced If An Accelerated Death Benefit Is Paid.

When Payable: We will pay the Accelerated Death Benefit while this Policy is in Full Force upon receipt during your lifetime of the following:

- (a) due proof that you have a Terminal Illness;
- (b) the consent of any irrevocable beneficiary, Owner, or any other legally required consent; and
- (c) evidence that election of this Benefit is voluntary and without coercion on the part of any third party.

We may require, at our expense, an additional examination by a Physician of our choice before payment of the Accelerated Death Benefit.

The Accelerated Death Benefit will be paid in a lump sum to the Owner unless the benefit has been otherwise assigned or designated by the Owner. For Intermediate Limited Endowment policies, the amount payable as a lump sum will be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans.

If you die after the Owner elects to receive the Accelerated Death Benefit but before any benefit is paid, the election will be cancelled and the death benefit will be paid pursuant to the Policy provisions.

DEFINITIONS:

Accelerated Death Benefit: The Accelerated Death Benefit will be equal to the lesser of 75% of your Death Benefit at the time of claim or \$300,000, less any assignments in excess of 25% of the Death Benefit. If applicable, the Accelerated Death Benefit will be reduced by the full amount of any outstanding loan. The amount of the Accelerated Death Benefit will be calculated as of the Date of the Physician's written statement that you have a Terminal Illness. Only one Accelerated Death Benefit will be payable under any policy.

The amount of the Accelerated Death Benefit does not include any riders or benefits attached to and made part of the Policy.

Physician means a duly licensed practitioner of the healing arts practicing within the scope of the license. A Physician must not be you or related to you as a spouse, parent, child, grandchild, sibling, son-in-law, or daughter-in-law, and must not usually live in your household.

Terminal Illness means a condition that a Physician predicts, in his or her best medical judgment, will cause you to die within 6 months. The Terminal Illness must be diagnosed after the Effective Date of the Policy and while the Accelerated Death Benefit is in Full Force.

Effect on Policy: At the time of your death, the Death Benefit payable under the Policy will be reduced by the amount of any Accelerated Death Benefit that has been paid under this Policy. For Intermediate Limited Endowment policies, the Endowment Benefit will still be payable if the Policy is in force at the end of the Endowment Period as described in the Policy.

Prior to or concurrent with the election to accelerate the policy death benefits, the Owner and any irrevocable beneficiary will be given a statement demonstrating the effect the payment of the Accelerated Death Benefit has on the Death Benefit, and if applicable, the cash value and loan value.

After an Accelerated Death Benefit is payable, premiums for the Policy and any attached riders and benefits will be waived. In order for us to waive premiums for more than 12 months, we will require a Physician's statement that continues to predict that you will die in 6 months. We may require a Physician's statement once a year thereafter. If we do not receive such a statement, we will no longer waive the premiums. You will then be required to pay the premiums.

Any benefits and riders attached to the Policy will not be affected by the payment of the Accelerated Death Benefit. No additional riders or benefits may be added to the Policy after an Accelerated Death Benefit has been paid. No changes to the coverage under the Policy nor any additional loans may be made after an Accelerated Death Benefit has been paid, unless approved by us.

Termination: The Accelerated Death Benefit will terminate on the earlier of:

- (a) lapse or termination of the Policy to which it is attached; or
- (b) written request by the Owner; or
- (c) payment of an Accelerated Death Benefit.

Termination will not affect our payment of any existing claim.

Consideration: There is no specific premium for this benefit.

Policy Provisions: This Amendment is part of the Policy to which it is attached. The Policy provisions remain in effect except as specifically changed by this Amendment.



Secretary



1. Does Proposed Insured Qualify for Simplified Issue Coverage?

IF YOU ANSWER 'YES' TO ANY OF THE FOLLOWING QUESTIONS, DO NOT APPLY FOR COVERAGE.

- 1. Is Height 5' 10" and Weight 180 out of acceptable range of build chart on page four? ...
2. Have you ever received any treatment, medical advice, or consultation for; been diagnosed with; or required follow-up for:
(a) cancer (other than basal cell or squamous cell carcinoma of the skin)?
(b) type I diabetes or elevated blood sugar that required treatment with insulin?
(c) type II diabetes or elevated blood sugar AND, in the last year, had average daily blood sugar readings of more than 200 mg/dl or failed to consistently check your blood sugar?
(d) diabetic complications, such as numbness, poor circulation, leg ulcers, amputation or kidney disorders?
(e) epilepsy, seizures, stroke, paralysis, Alzheimer's disease or dementia?
(f) degenerative muscle or nerve disease/disorder?
(g) major depression, bipolar (mood) disorder or schizophrenia?
(h) rheumatoid arthritis, lupus or any other connective tissue disease?
(i) Crohn's or Ulcerative Colitis AND had an attack within the last two years?
(j) chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema or any other chronic lung disease or disorder (other than mild asthma)?
(k) any disease or disorder of the heart, aorta, coronary arteries, peripheral arteries, blood, liver, pancreas, kidney (other than kidney stones) or central nervous system?
3. Have you ever been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or have you tested positive for HIV (Human Immunodeficiency Virus)?
4. Are you waiting for a diagnosis or have you been advised to have a surgical operation, diagnostic test, medical evaluation, or mental evaluation that has not yet been completed?
5. In the past 5 years, have you:
(a) been convicted of, or pled guilty or no contest to more than one offense of DWI/DUI?
(b) served in a probation or parole program due to the conviction of any crime?
(c) been arrested for, convicted of, or pled guilty or no contest to any felony or misdemeanor or to possession or distribution of drugs or any other illegal substance?
(d) used cocaine, crack, heroin, methamphetamine or any illegal substance?
(e) been advised by a healthcare professional to reduce or stop alcohol or drug use (including prescription drugs)?
(f) required the use of a walker (other than for acute fractures), wheelchair, electric scooter, oxygen or catheter?
6. In the past 3 years, have you been hospitalized or evaluated in an emergency room or immediate care center for any illness or condition (other than for acute fractures) that required ongoing treatment or follow-up by a physician?
7. In the past 2 years, have you had your driver's license suspended or revoked, had 4 or more moving violations, or been convicted of or pled guilty or no contest to a DWI/DUI?
8. Do you currently take or have you in the last 12 months been prescribed more than two prescription medications for pain?
9. Do you currently take or have you in the last 12 months been prescribed more than two prescription medications for any type of depression, anxiety or any other mental or nervous disorder?
10. Do you consume, on average, more than 4 alcoholic beverages per day?
11. Are you active in the military with orders to be deployed outside the US or US Territories?
12. Are you a citizen of a country other than the US or residing in the US with a non-permanent visa?
13. Do you intend to sell the applied-for life insurance policy within the next 5 years?

2. Proposed Insured Information

Name John Q. Doe SSN 123-45-6789 Male Female
Date of Birth 01 / 01 / 1973 State of Birth SC Marital Status Single
Residence Address Required (No PO Box) 123 Any Street Anywhere, SC 12345
Mailing Address (if different from Residence Address)
Daytime Phone (xxx) xxx-xxxx Evening Phone ()
Email JDoe@yahoo.com

Proposed Insured Name _____

2. Proposed Insured Information (Continued)

- 1. Driver's License # 12345678 Issue State SC
- 2. Occupation Teacher Annual Income \$ 60,000
- 3. In the past 5 years, have you applied for, requested or received Social Security disability benefits or Worker's Compensation income benefits for more than 60 consecutive days?..... Yes No

If you do not have a driver's license, are unemployed or answered 'YES' to question #3 above, please explain details in the Remarks section on page 4.

3. Is the Proposed Insured the Owner? Yes No If No, complete this section.

Owner Name _____ SSN _____ Male Female
First MI Last

Date of Birth ____/____/____ Relationship to Proposed Insured _____
MM DD YYYY

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

Address Address

City State Zip Code City State Zip Code

Daytime Phone () _____

4. Is the Proposed Insured the Payor? Yes No If No, complete this section.

Payor Name _____ SSN _____ Male Female
First MI Last

Date of Birth ____/____/____ Relationship to Proposed Insured _____
MM DD YYYY

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

Address Address

City State Zip Code City State Zip Code

Daytime Phone () _____

5. Beneficiary Information - If more space is needed, provide information in the Remarks section on page 4.

| Primary Beneficiary | % of Proceeds | Relationship to Insured | Date of Birth |
|------------------------|---------------|-------------------------|---------------|
| Mary Doe | 100% | Mother | 01/02/1943 |
| | 100% | | |
| Contingent Beneficiary | % of Proceeds | Relationship to Insured | Date of Birth |
| | 100% | | |
| | 100% | | |

6. Plan of Insurance

Face Amount \$ _____

Check (✓) One [Level Term Plan]

15 year

20 year

30 year

30 year [with ROP Endowment]

Premium Class

1. In the past twelve months, have you used any form of tobacco products or nicotine delivery systems?
 Yes, Tobacco Class No, Non-Tobacco Class

Optional Benefits and Riders

Accidental Death

Waiver of Premium

Child Rider

Accident Only Disability

(answer question 2 below)

Benefit Amount

\$ 5,000

\$ _____ monthly*

Accident Only Disability

IF YOU ANSWER 'YES' TO THE FOLLOWING QUESTION, DO NOT APPLY FOR THIS OPTIONAL BENEFIT.

2. Are you currently self employed, working as an independent contractor, or working less than 30 hours per week? Yes No

***Monthly Benefit Amount limited to lesser of 1.5% of the face amount or \$1,500**

7. Recurring Payment Information

- Monthly Bank Draft (EFT) - **Attach Voided Check and Payment Authorization Form**
 - Semi-Annual Direct Bill
 - Annual Direct Bill
 - Quarterly Direct Bill
 - Credit Card - **Complete Credit Card Authorization Form**
- Total Modal Premium \$ _____

8. Do You Have a Physician? Yes No **If Yes, complete this section.**

Proposed Insured's Physician: _____
 City _____ State _____ Phone () _____

9. Existing Coverage

1. Do you have any existing life insurance or annuity contracts? Yes No **If Yes, submit required replacement forms.**

10. Acknowledgement

By signing below, each person applying for coverage represents and agrees to the following:

I have read the application and the statements and answers made in this application are true and complete and are made to obtain the insurance applied for. I understand that the insurance I applied for 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) the proposed insured is alive, and (3) all conditions used to determine the proposed insured's insurability remain as stated in the application. No one except the Company's Home Office officers may make, change or discharge any insurance contract, or bind the Company by making any promises about any policy benefits applied for.

[I 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 benefit manager, insurance company or reinsurer, financial institution, 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 Death Benefit Disclosure - By signing below, I acknowledge that I have received and read, if applicable, the Accelerated Death Benefit Disclosure Statement.

For Residents of Arkansas: 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.

Dated and Signed at Any City SC on August 26 2010
City State Month Day

John Q. Doe
 Printed Name of Proposed Insured

X John Q. Doe
 Signature of Proposed Insured

 Printed Name of Owner
 (if other than Proposed Insured)

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

Proposed Insured Name _____

11. Agent's Statement

Does the Proposed Insured have any existing life insurance or annuity contracts? - - - - - Yes No
 I have truly and accurately recorded the information given by the Proposed Insured, to the best of my knowledge.

RB Liberty _____

X *RB Liberty* _____

Printed Name of Writing Agent (Required)

Signature of Writing Agent (as Witness)

12. Writing Agent Information

Agent/Representative's Printed Name _____ Writing Agent No. _____

Commissions Split: _____ % Agent Name and No. _____

_____ % Agent Name and No. _____

Email Address _____ Phone Number () _____ Fax Number () _____

Marketing Organization Name _____ Address _____

Key Contact Name _____ Email Address _____ Phone Number _____

Agency Manager's Name _____ Email Address _____

13. Remarks

Reason(s) for No Driver's License: _____

Details of Unemployment: _____

Details of Disability: _____

Household Income (Required if unemployed): \$ _____

14. [EasyTerm and EasyTerm Plus] Build Chart

| Height | 4' 8" | 4' 9" | 4' 10" | 4' 11" | 5' 0" | 5' 1" | 5' 2" | 5' 3" | 5' 4" | 5' 5" | 5' 6" | 5' 7" | 5' 8" | 5' 9" | 5' 10" | 5' 11" | 6' 0" | 6' 1" | 6' 2" | 6' 3" | 6' 4" | 6' 5" | 6' 6" | 6' 7" | 6' 8" | 6' 9" | 6' 10" | 6' 11" |
|--------------|-------|-------|--------|--------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------|--------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|--------|--------|
| Do Not Apply | < 81 | < 84 | < 86 | < 89 | < 92 | < 96 | < 99 | < 102 | < 105 | < 108 | < 112 | < 115 | < 119 | < 122 | < 126 | < 129 | < 133 | < 137 | < 140 | < 144 | < 148 | < 152 | < 156 | < 160 | < 164 | < 168 | < 172 | < 177 |
| Min Weight | 81 | 84 | 86 | 89 | 92 | 96 | 99 | 102 | 105 | 108 | 112 | 115 | 119 | 122 | 126 | 129 | 133 | 137 | 140 | 144 | 148 | 152 | 156 | 160 | 164 | 168 | 172 | 177 |
| Max Weight | 198 | 203 | 209 | 215 | 220 | 227 | 233 | 239 | 246 | 250 | 259 | 265 | 274 | 282 | 293 | 299 | 305 | 315 | 325 | 335 | 345 | 355 | 365 | 370 | 372 | 375 | 380 | 385 |
| Do Not Apply | 199 + | 204 + | 210 + | 216 + | 221 + | 228 + | 234 + | 240 + | 247 + | 251 + | 260 + | 266 + | 275 + | 283 + | 294 + | 300 + | 306 + | 316 + | 326 + | 336 + | 346 + | 356 + | 366 + | 371 + | 373 + | 376 + | 381 + | 386 + |

15. Home Office Amendment(s)



1. Proposed Insured Information

Name John Q. Doe SSN 123-45-6789 Male Date of Birth 01/01/1973 State of Birth SC Marital Status Single Residence Address Required 123 Any Street Anywhere, SC 12345 Mailing Address (if different from Residence Address) Daytime Phone (xxx) xxx-xxxx Evening Phone () Email JDoe@yahoo.com 1. Driver's License # 12345678 Issue State SC 2. Occupation Teacher Annual Income \$ 60,000 If you do not have a driver's license or are unemployed, please explain details in the Remarks section on page 4.

2. Is the Proposed Insured the Owner? Yes No If No, complete this section.

Owner Name SSN/TIN Male Female Date of Birth Relationship to Proposed Insured Residence Address Required Mailing Address (if different from Residence Address) Daytime Phone ()

3. Is the Proposed Insured the Payor? Yes No If No, complete this section.

Payor Name SSN/TIN Male Female Date of Birth Relationship to Proposed Insured Residence Address Required Mailing Address (if different from Residence Address) Daytime Phone ()

4. Beneficiary Information - If more space is needed, provide information in the Remarks section on page 4.

Table with 4 columns: Beneficiary Name, % of Proceeds, Relationship to Insured, Date of Birth. Row 1: Mary Doe, 100%, Mother, 01/02/1943. Row 2: Contingent Beneficiary, 100%, Relationship to Insured, Date of Birth.

5. Plan of Insurance

Face Amount \$ 100,000

Check (✓) One [Level Term Plan]

- 15 year
- 20 year
- 30 year
- 30 year [with ROP Endowment]

Premium Class

- | | |
|--|---|
| <p>1. In the past twelve months, have you used any form of tobacco products or nicotine delivery systems?</p> <p><input type="checkbox"/> YES, select one of the Tobacco premium classes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Standard Tobacco | <p><input checked="" type="checkbox"/> NO, select one of the Non-Tobacco premium classes:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Super Preferred Non-Tobacco <input type="checkbox"/> Preferred Non-Tobacco <input type="checkbox"/> Standard Non-Tobacco |
|--|---|

Optional Benefits and Riders

- | | |
|--|---|
| <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Accidental Death <input type="checkbox"/> Critical Illness <input type="checkbox"/> Child Rider <input checked="" type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accident Only Disability <p>(answer question 2 below)</p> | <p>Benefit Amount</p> <p>\$ <u>100,000</u></p> <p>\$ _____</p> <p>\$ <u>5,000</u></p> <p>\$ _____ monthly*</p> |
|--|---|

Accident Only Disability

IF YOU ANSWER 'YES' TO THE FOLLOWING QUESTION, DO NOT APPLY FOR THIS OPTIONAL BENEFIT.

2. Are you currently self employed, working as an independent contractor, or working less than 30 hours per week? Yes No

***Monthly Benefit Amount limited to lesser of 1.5% of the face amount or \$1,500**

6. Personal Information

1. Have your natural parents, brothers or sisters died from cancer, diabetes, or cardiovascular disease prior to age 60?..... Yes No
 2. Have you ever had an application for life, accident, health, or disability insurance rated, postponed or declined? Yes No
 3. Do you currently have an application or informal inquiry for life insurance pending with any company? Yes No
- IF YOU ANSWER 'YES' TO ANY OF THE FOLLOWING QUESTIONS, DO NOT APPLY FOR COVERAGE.**
4. Are you a citizen of a country other than the US or residing in the US with a non-permanent visa?..... Yes No
 5. Have you ever been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or have you tested positive for HIV (Human Immunodeficiency Virus)? Yes No
 6. Are you waiting for a diagnosis or have you been advised to have a surgical operation, diagnostic test, medical evaluation, or mental evaluation that has not yet been completed? Yes No
 7. Do you intend to sell the applied-for life insurance policy within the next 5 years? Yes No
- IF YOU ANSWER 'YES' TO ANY OF THE FOLLOWING QUESTIONS, CONTACT CASECARE@RBC.COM BEFORE APPLYING.**
8. In the past 3 years, have you
 - (a) been charged with DUI/DWI, had 4 or more moving violations, had a motor vehicle 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 do you intend to do so? Yes No
 - (c) engaged in underwater diving below 50 feet, racing of any motor powered land vehicle or watercraft, rock or mountain climbing, or any activity requiring the use of a parachute, or do you intend to do so in the next 2 years? Yes No
 9. Have you ever been arrested for, convicted of, or pled guilty or no contest to any felony or misdemeanor or to possession or distribution of drugs or any other illegal substance? Yes No
(If Yes, please include charges, dates and locations of arrests.)
 10. Do you consume, on average, more than 4 alcoholic beverages per day? Yes No
 11. In the past 10 years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; or required follow-up for: disease or disorder of the heart, lung, kidney, pancreas, liver, colon, brain or nervous system; diabetes; stroke; or cancer?..... Yes No
 12. 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 dates and locations.)

Provide details to all 'Yes' responses in the Remarks section on page 4.

7. Recurring Payment Information

- Monthly Bank Draft (EFT) - **Attach Voided Check and Payment Authorization Form**
 - Semi-Annual Direct Bill
 - Annual Direct Bill
 - Quarterly Direct Bill
 - Credit Card - **Complete Credit Card Authorization Form**
- Total Modal Premium \$ _____

8. Do You Have a Physician? Yes No **If Yes, complete this section.**

Proposed Insured's Physician: _____
 City _____ State _____ Phone () _____

9. Existing Coverage

1. Do you have any existing life insurance or annuity contracts? Yes No
If Yes, submit required replacement forms and provide details below.

| Name on Policy | Company | Date of Issue (mm/yy) | Benefit Amount |
|----------------|---------|--------------------------|----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

10. Acknowledgement

By signing below, each person applying for coverage represents and agrees to the following:

I have read the application and the statements and answers made in this application are true and complete and are made to obtain the insurance applied for. I understand that the insurance I applied for 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) the proposed insured is alive, and (3) all conditions used to determine the proposed insured's insurability remain as stated in the application. No one except the Company's Home Office officers may make, change or discharge any insurance contract, or bind the Company by making any promises about any policy benefits applied for.

[I 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 benefit manager, insurance company or reinsurer, financial institution, 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 Death Benefit Disclosure - By signing below, I acknowledge that I have received and read, if applicable, the Accelerated Death Benefit Disclosure Statement.

For Residents of Arkansas: 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 for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated and Signed at _____ Any City _____ SC on _____ August _____ 26 _____ 2010 _____
City State Month Day

John Q. Doe _____

X *John Q. Doe* _____

Printed Name of Proposed Insured

Signature of Proposed Insured

Printed Name of Owner
(if other than Proposed Insured)

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

Proposed Insured Name _____

11. Agent's Statement

Does the Proposed Insured have any existing life insurance or annuity contracts? - - - - - Yes No
 I have truly and accurately recorded the information given by the Proposed Insured, to the best of my knowledge.

RB Liberty _____

X *RB Liberty* _____

Printed Name of Writing Agent (Required)

Signature of Writing Agent (as Witness)

12. Writing Agent Information

Agent/Representative's Printed Name _____ Writing Agent No. _____

Commissions Split: _____ % Agent Name and No. _____

_____ % Agent Name and No. _____

Email Address _____ Phone Number () _____ Fax Number () _____

Marketing Organization Name _____ Address _____

Key Contact Name _____ Email Address _____ Phone Number _____

Agency Manager's Name _____ Email Address _____

13. Remarks

Reason(s) for No Driver's License: _____

Details of Unemployment: _____

Household Income (Required if unemployed): \$ _____

14. [Term and Term Plus] Build Chart

| Height | 4' 10" | 4' 11" | 5' 0" | 5' 1" | 5' 2" | 5' 3" | 5' 4" | 5' 5" | 5' 6" | 5' 7" | 5' 8" | 5' 9" | 5' 10" | 5' 11" | 6' 0" | 6' 1" | 6' 2" | 6' 3" | 6' 4" | 6' 5" | 6' 6" | 6' 7" | 6' 8" | 6' 9" |
|------------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Super Preferred Non Tobacco | 144 | 149 | 155 | 160 | 166 | 172 | 176 | 181 | 187 | 192 | 198 | 204 | 209 | 215 | 221 | 228 | 234 | 241 | 247 | 253 | 260 | 268 | 274 | 281 |
| All Preferred Classes | 167 | 173 | 178 | 184 | 191 | 197 | 203 | 210 | 216 | 223 | 229 | 236 | 243 | 250 | 257 | 264 | 272 | 279 | 287 | 294 | 302 | 310 | 318 | 326 |
| All Standard Classes | 179 | 185 | 192 | 198 | 205 | 211 | 218 | 225 | 232 | 239 | 246 | 253 | 261 | 268 | 276 | 284 | 292 | 300 | 308 | 316 | 324 | 332 | 341 | 349 |
| email casecare@rbc.com for a quote | 180 - 227 | 186 - 235 | 193 - 243 | 199 - 251 | 206 - 259 | 212 - 268 | 219 - 276 | 226 - 285 | 233 - 294 | 240 - 303 | 247 - 312 | 254 - 321 | 262 - 331 | 269 - 340 | 277 - 350 | 285 - 360 | 293 - 369 | 301 - 380 | 309 - 390 | 317 - 400 | 325 - 411 | 333 - 421 | 342 - 432 | 350 - 443 |
| Do Not Apply | 228+ | 236+ | 244+ | 252+ | 260+ | 269+ | 277+ | 286+ | 295+ | 304+ | 313+ | 322+ | 332+ | 341+ | 351+ | 361+ | 370+ | 381+ | 391+ | 401+ | 412+ | 422+ | 433+ | 444+ |

15. Home Office Amendment(s)

SERFF Tracking Number: LBLI-126793451 State: Arkansas
 Filing Company: Liberty Life Insurance Company State Tracking Number: 46769
 Company Tracking Number: LTR3006TIB(06-10)
 TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life -
 Fixed/Indeterminate Premium
 Product Name: Apps and TIB rider
 Project Name/Number: /

Supporting Document Schedules

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Flesch Certification | | |
| Comments: | | |
| Attachment: READ N AL_AR.pdf | | |

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Accelerated Death Benefit Disclosure Stmt and Claim Disclosure | | |
| Comments: These forms are being provided for your information. | | |
| Attachments: LTR3006TIBD(06-10).pdf LTR3006TIBC(06-10).pdf | | |

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Statements of Variability | | |
| Comments: | | |
| Attachments: SOV SI N.pdf SOV UW N.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> |
|---|--------------------|---------------------|
| Amendment | LTR3006TIB(06-10) | 52.0 |
| Simplified Issue Individual Term Life Insurance Application | LTA3009NSN(01-11) | 50.4 |
| Individual Term Life Insurance Application | LTA3010NUN(01-11) | 50.1 |

September 1, 2010
Date



Mark S. Wessel
Compliance Officer Policy Forms/Compliance

ACCELERATED DEATH BENEFIT DISCLOSURE STATEMENT

An Accelerated Death Benefit for Terminal Illness is an inherent benefit in the Policy you have been issued. The description below briefly covers the Accelerated Benefit. The actual Policy provisions will prevail. **Please Read Your Policy Carefully.**

Accelerated Death Benefit For Terminal Illness

The Accelerated Death Benefit Paid Under This Policy May Be Taxable. If So, The Owner May Incur A Tax Obligation. As With All Tax Matters, The Owner Should Seek Additional Information From His Personal Tax Advisor About The Tax Status Of The Accelerated Death Benefit Payment.

The Death Benefit And, If Applicable, Cash Values And Loan Values Will Be Reduced If An Accelerated Death Benefit Is Paid.

Receipt Of The Accelerated Death Benefit May Affect Your Eligibility For Medicaid Or Other Government Benefits Or Entitlements And May Have Income Tax Consequences.

When Payable: We will pay the Accelerated Death Benefit while this Policy is in Full Force upon receipt during your lifetime of the following:

- (a) due proof that you have a Terminal Illness;
- (b) the consent of any irrevocable beneficiary, Owner, or any other legally required consent; and
- (c) evidence that election of this Benefit is voluntary and without coercion on the part of any third party.

We may require, at our expense, an additional examination by a Physician of our choice before payment of the Accelerated Death Benefit.

The Accelerated Death Benefit will be paid in a lump sum to the Owner unless the benefit has been otherwise assigned or designated by the Owner. For Intermediate Limited Endowment policies, the amount payable as a lump sum will be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans.

If you die after the Owner elects to receive the Accelerated Death Benefit but before any benefit is paid, the election will be cancelled and the death benefit will be paid pursuant to the Policy provisions.

DEFINITIONS:

Accelerated Death Benefit: The Accelerated Death Benefit will be equal to the lesser of 75% of your Death Benefit at the time of claim or \$300,000, less any assignments in excess of 25% of the Death Benefit. If applicable, the Accelerated Death Benefit will be reduced by the full amount of any outstanding loan. The amount of the Accelerated Death Benefit will be calculated as of the Date of the Physician's written statement that you have a Terminal Illness. Only one Accelerated Death Benefit will be payable under any policy.

The amount of the Accelerated Death Benefit does not include any riders or benefits attached to and made part of the Policy.

Physician means a duly licensed practitioner of the healing arts practicing within the scope of the license. A Physician must not be you or related to you as a spouse, parent, child, grandchild, sibling, son-in-law, or daughter-in-law, and must not usually live in your household.

Terminal Illness means a condition that a Physician predicts, in his or her best medical judgment, will cause you to die within 6 months. The Terminal Illness must be diagnosed after the Effective Date of the Policy and while the Accelerated Death Benefit is in Full Force.

Effect on Policy: At the time of your death, the Death Benefit payable under the Policy will be reduced by the amount of any Accelerated Death Benefit that has been paid under this Policy. For Intermediate Limited Endowment policies, the Endowment Benefit will still be payable if the Policy is in force at the end of the Endowment Period as described in the Policy.

After an Accelerated Death Benefit is payable, premiums for the Policy and any attached riders and benefits will be waived. In order for us to waive premiums for more than 12 months, we will require a Physician's statement that continues to predict that you will die in 6 months. We may require a Physician's statement once a year thereafter. If we do not receive such a statement, we will no longer waive the premiums. You will then be required to pay the premiums.

Any benefits and riders attached to the Policy will not be affected by the payment of the Accelerated Death Benefit. No additional riders or benefits may be added to the Policy after an Accelerated Death Benefit has been paid. No changes to the coverage under the Policy nor any additional loans may be made after an Accelerated Death Benefit has been paid, unless approved by us.

Termination: The Accelerated Death Benefit will terminate on the earlier of:

- (a) lapse or termination of the Policy to which it is attached; or
- (b) written request by the Owner; or
- (c) payment of an Accelerated Death Benefit.

Termination will not affect our payment of any existing claim.

After an Accelerated Death Benefit is payable, premiums for the Policy and any attached riders and benefits will be waived.

ACCELERATED DEATH BENEFIT DISCLOSURE STATEMENT

An Accelerated Death Benefit for Terminal Illness is an inherent benefit in the Policy you have been issued. The description below briefly covers the Accelerated Benefit. The actual Policy provisions will prevail. **Please Read Your Policy Carefully.**

Accelerated Death Benefit For Terminal Illness

The Accelerated Death Benefit Paid Under This Policy May Be Taxable. If So, The Owner May Incur A Tax Obligation. As With All Tax Matters, The Owner Should Seek Additional Information From His Personal Tax Advisor About The Tax Status Of The Accelerated Death Benefit Payment.

The Death Benefit And, If Applicable, Cash Values And Loan Values Will Be Reduced If An Accelerated Death Benefit Is Paid.

Receipt Of The Accelerated Death Benefit May Affect Your Eligibility For Medicaid Or Other Government Benefits Or Entitlements And May Have Income Tax Consequences.

When Payable: We will pay the Accelerated Death Benefit while this Policy is in Full Force upon receipt during your lifetime of the following:

- (a) due proof that you have a Terminal Illness;
- (b) the consent of any irrevocable beneficiary, Owner, or any other legally required consent; and
- (c) evidence that election of this Benefit is voluntary and without coercion on the part of any third party.

We may require, at our expense, an additional examination by a Physician of our choice before payment of the Accelerated Death Benefit.

The Accelerated Death Benefit will be paid in a lump sum to the Owner unless the benefit has been otherwise assigned or designated by the Owner. For Intermediate Limited Endowment policies, the amount payable as a lump sum will be at least equal to the acceleration percentage multiplied by the difference between the current policy cash value and any outstanding policy loans.

If you die after the Owner elects to receive the Accelerated Death Benefit but before any benefit is paid, the election will be cancelled and the death benefit will be paid pursuant to the Policy provisions.

DEFINITIONS:

Accelerated Death Benefit: The Accelerated Death Benefit will be equal to the lesser of 75% of your Death Benefit at the time of claim or \$300,000, less any assignments in excess of 25% of the Death Benefit. If applicable, the Accelerated Death Benefit will be reduced by the full amount of any outstanding loan. The amount of the Accelerated Death Benefit will be calculated as of the Date of the Physician's written statement that you have a Terminal Illness. Only one Accelerated Death Benefit will be payable under any policy.

The amount of the Accelerated Death Benefit does not include any riders or benefits attached to and made part of the Policy.

Physician means a duly licensed practitioner of the healing arts practicing within the scope of the license. A Physician must not be you or related to you as a spouse, parent, child, grandchild, sibling, son-in-law, or daughter-in-law, and must not usually live in your household.

Terminal Illness means a condition that a Physician predicts, in his or her best medical judgment, will cause you to die within 6 months. The Terminal Illness must be diagnosed after the Effective Date of the Policy and while the Accelerated Death Benefit is in Full Force.

Effect on Policy: At the time of your death, the Death Benefit payable under the Policy will be reduced by the amount of any Accelerated Death Benefit that has been paid under this Policy. For Intermediate Limited Endowment policies, the Endowment Benefit will still be payable if the Policy is in force at the end of the Endowment Period as described in the Policy.

After an Accelerated Death Benefit is payable, premiums for the Policy and any attached riders and benefits will be waived. In order for us to waive premiums for more than 12 months, we will require a Physician's statement that continues to predict that you will die in 6 months. We may require a Physician's statement once a year thereafter. If we do not receive such a statement, we will no longer waive the premiums. You will then be required to pay the premiums.

Any benefits and riders attached to the Policy will not be affected by the payment of the Accelerated Death Benefit. No additional riders or benefits may be added to the Policy after an Accelerated Death Benefit has been paid. No changes to the coverage under the Policy nor any additional loans may be made after an Accelerated Death Benefit has been paid, unless approved by us.

Termination: The Accelerated Death Benefit will terminate on the earlier of:

- (a) lapse or termination of the Policy to which it is attached; or
- (b) written request by the Owner; or
- (c) payment of an Accelerated Death Benefit.

Termination will not affect our payment of any existing claim.

Current Values

Current Death Benefit \$ _____

Outstanding Loan Amount
(if applicable) \$ _____

Cash Value (if applicable) \$ _____

Accelerated Death Benefit Amount \$ _____

Remaining Values after Accelerated Death Benefit Payment

Remaining Death Benefit
(net of liens and loans) \$ _____

Remaining Loan Amount
(if applicable) \$ _____

Cash Value
(if applicable, net of liens and loans) \$ _____

After an Accelerated Death Benefit is payable, premiums for the Policy and any attached riders and benefits will be waived.

Insured Signature

Owner Signature (if other than Insured)

Date

Statement of Variability
Application Form No. **LTA3009NSN(01-11)**

1. Company address.
2. **Plan of Insurance** - This plan of insurance will always be identified as a level term product; however, another marketing name may be used.
 - a. Optional Benefits and Riders- brackets have been placed around the benefits and riders because they may change based on the availability in your state.
 - b. The Accident Only Disability question will only appear if the Rider is approved in your state.
3. **Payment Information** – The payment method offered will vary. Additionally, the name of the Payment Authorization Form may be changed to another title.
4. **Acknowledgement** – The sentence regarding insurance/credit disclosures will only appear if the product is offered through a financial institution.
5. **Section 14-** The name of the products ‘Easy Term and Easy Term Plus’ may or may not appear and may be changed to another marketing name.

Statement of Variability
Application Form No. LTA3010NUN(01-11)

1. Company address.
2. **Plan of Insurance** – This plan of insurance will always be identified as a level term product; however, another marketing name may be used.
 - a. Optional Benefits and Riders- brackets have been placed around the benefits and riders because they may change based on the availability in your state.
 - b. The Accident Only Disability question will only appear if it is approved in your state.
3. **Payment Information** – The payment method offered will vary. Additionally, the name of the Payment Authorization Form may be changed to another title.
4. **Acknowledgement** – The sentence regarding insurance/credit disclosures will only appear if the product is offered through a financial institution.
5. **Section 14-** The name of the products 'Term and Term Plus' may or may not appear and may be changed to another marketing name.