Filing at a Glance

Company: Liberty Bankers Life Insurance Company

Product Name: New Applications	SERFF Tr Num: LBLI-127623580	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 49885
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: NEWAPP	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Chad Leiding	Disposition Date: 10/06/2011
	Date Submitted: 09/27/2011	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:
State Filing Description:		

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Chad Leiding
Filing Description:
Liberty Bankers Life Insurance Company
NAIC# 68543
FEIN# 25-1093277

LBL-SIM-APP-0911 SIMPL Policy Application
LBL-WL-APP (0811) Full Policy Application
LBL-HS-APP-0911 Home Service Policy Application

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 09/23/2011
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/06/2011
State Status Changed: 10/03/2011
Created By: Chad Leiding
Corresponding Filing Tracking Number:

To whom it may concern:

The above listed forms are submitted for your review and approval. These forms are new and are not intended to replace any previously approved forms. These forms have been submitted to our state of domicile for approval concurrently with this filing.

LBL-WL-APP (0811) is the new policy application that will be used with previously approved life policy forms LBL-SIWL-0806-AR, LBL-WL-POL-0407-AR, LBL-TERM20-0607-AR, LBL-TERM20-RPU-0607-AR, LBL TERM70/20-RPU-0110-AR, and LBL-TERM-0211-AR. The application is similar to previously approved application LBL-WL-APP (0307) (SERFF Tracking # LBLI-125181622 approved on 6/14/07). We have updated some of the MIB language in PART 3 as well as a few medical questions.

LBL-SIM-APP-0911 is the new policy application that will be used with previously approved policy forms LBL-SIWL-0806-AR and LBL-WL-POL-0407-AR. The application is similar to previously approved application LBL-SIM-APP-0610 (SERFF Tracking # LBLI-125599290 approved on 4/18/08). We have updated some of the MIB language in PART 3 as well as a few medical questions. This application differs from LBL-WL-APP (0811) in that it's a shorter application with fewer underwriting questions and is intended to be more of a simplified issue application.

LBL-HS-APP-0911 will be used by our home service agents. This application is very similar to LBL-SIM-APP-0911. This application will be used with previously approved policy forms LBL-SIWL-0806-AR and LBL-WL-POL-0407-AR. The application is similar to previously approved application LBL-HS-APP-1008 (SERFF Tracking # LBLI-126064323 approved on 3/13/09). We have updated some of the MIB language in PART 3 as well as a few medical questions.

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

Company and Contact

Filing Contact Information

Chad Leiding, V.P Compliance
1800 Valley View Lane
Suite 300
Dallas, TX 75234

chad.leiding@libertybankerslife.com
469-522-4332 [Phone]
469-522-4380 [FAX]

Filing Company Information

Liberty Bankers Life Insurance Company	CoCode: 68543	State of Domicile: Oklahoma
1800 Valley View Lane	Group Code: 3436	Company Type: LAH
Suite 300	Group Name:	State ID Number:

Dallas, TX 75234 FEIN Number: 25-1093227

(469) 522-4332 ext. [Phone]

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Liberty Bankers Life Insurance Company	$150.00	09/27/2011	52169245

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/06/2011	10/06/2011
Approved-Closed	Linda Bird	10/03/2011	10/03/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	SIMPL Policy Application	Chad Leiding	10/05/2011	10/05/2011
Form	Full Policy Application	Chad Leiding	10/05/2011	10/05/2011
Form	Home Service Policy Application	Chad Leiding	10/05/2011	10/05/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Wrong applications	Note To Filer	Linda Bird	10/05/2011	10/05/2011
Wrong applications	Note To Reviewer	Chad Leiding	10/04/2011	10/04/2011

Disposition

Disposition Date: 10/06/2011

Implementation Date:

Status: Approved-Closed

Comment: Company has submitted correct applications for this filing.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LBLI-127623580*	*State:*	*Arkansas*
Filing Company:	*Liberty Bankers Life Insurance Company*	*State Tracking Number:*	*49885*
Company Tracking Number:	*NEWAPP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*New Applications*		
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
Form *(revised)*	SIMPL Policy Application		Yes
Form	SIMPL Policy Application	Replaced	Yes
Form *(revised)*	Full Policy Application		Yes
Form	Full Policy Application	Replaced	Yes
Form *(revised)*	Home Service Policy Application		Yes
Form	Home Service Policy Application	Replaced	Yes

Disposition

Disposition Date: 10/03/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LBLI-127623580*	*State:*	*Arkansas*
Filing Company:	*Liberty Bankers Life Insurance Company*	*State Tracking Number:*	*49885*
Company Tracking Number:	*NEWAPP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*New Applications*		
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
Form *(revised)*	SIMPL Policy Application		Yes
Form	SIMPL Policy Application	Replaced	Yes
Form *(revised)*	Full Policy Application		Yes
Form	Full Policy Application	Replaced	Yes
Form *(revised)*	Home Service Policy Application		Yes
Form	Home Service Policy Application	Replaced	Yes

SERFF Tracking Number:	*LBLI-127623580*	*State:*	*Arkansas*
Filing Company:	*Liberty Bankers Life Insurance Company*	*State Tracking Number:*	*49885*
Company Tracking Number:	*NEWAPP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*New Applications*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 10/05/2011

Comments:

Attached are the correct applications

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LBL-SIM-APP-0911	Application/Enrollment Form	SIMPL Policy Application	Initial				44.800	LBL-SIM-APP-0911-GENERIC.pdf
LBL-WL-APP (0811)	Application/Enrollment Form	Full Policy Application	Initial				48.800	LBL-WL-APP (0811)-Generic.pdf
LBL-HS-APP-0911	Application/Enrollment Form	Home Service Policy Application	Initial				44.800	LBL-HS-APP-0911-GENERIC.pdf

Note To Filer

Created By:

Linda Bird on 10/05/2011 08:12 AM

Last Edited By:

Linda Bird

Submitted On:

10/05/2011 08:12 AM

Subject:

Wrong applications

Comments:

Filing has been re-opened in order for correct applications to be submitted.

SERFF Tracking Number:	*LBLI-127623580*	*State:*	*Arkansas*
Filing Company:	*Liberty Bankers Life Insurance Company*	*State Tracking Number:*	*49885*
Company Tracking Number:	*NEWAPP*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*New Applications*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Chad Leiding on 10/04/2011 10:59 AM

Last Edited By:

Chad Leiding

Submitted On:

10/04/2011 11:00 AM

Subject:

Wrong applications

Comments:

Hello, the applications I submitted with this filing were for the wrong company. They were for our sister company Capitol Life. Can I submit the correct ones with this filing or do I need to do a new filing? They are exactly the same except for the form number.

Please advise.

Form Schedule

Lead Form Number: LBL-SIM-APP-0911

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LBL-SIM-APP-0911	Application/Enrollment Form	SIMPL Policy Application	Initial		44.800	LBL-SIM-APP-0911-GENERIC.pdf
	LBL-WL-APP (0811)	Application/Enrollment Form	Full Policy Application	Initial		48.800	LBL-WL-APP (0811)-Generic.pdf
	LBL-HS-APP-0911	Application/Enrollment Form	Home Service Policy Application	Initial		44.800	LBL-HS-APP-0911-GENERIC.pdf

Liberty Bankers Life
Insurance Company

Application for
"Simplified Issue Market"
Use with SIMPL/MWL

P.O. Box 224 Brownwood, Texas 76804-0224 ● 1-888-525-4467 ● FAX 1-888-525-5002 ● E-Mail: newbiz@lbladmin.com

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

Proposed Insured (First Name, Initial, Last Name)

_____

State of Birth _____ Country of Birth _____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

Social Security No. _____

Street Address _____

City, State, Zip _____ _____ _____

Home/Cell Phone _____

Work Phone: _____

E-Mail Address _____

Occupation _____

1. Have you used tobacco in any form in the past 12 months? ..... ☐ YES ☐ NO
2. Are you a US Citizen including resident alien? ☐ YES ☐ NO
   If No, please explain type of visa or work permit:_____
   _____

Plan Applied For: ☐ SIMPL ☐ MWL
☐ OTHER_____

Classification: ☐ Tobacco ☐ Non-Tobacco

Face Amount $_____

Premium Amount $_____

Amount paid with application $_____

Premium Mode:

☐ Monthly Bank Draft
Draft Day:_____

☐ Check here to draft first premium

☐ Monthly List Bill ☐ Bi-Weekly

☐ Payroll Deduction ☐ Quarterly

☐ Semi-Annual ☐ Annual

OWNER of Policy (if other than Proposed Insured)

_____

Relationship _____

Social Security No._____

Street Address _____

City, State, Zip _____ _____ _____

Home/Cell Phone_____

E-Mail _____

Primary Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone_____

E-Mail _____

Contingent Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone_____

E-Mail _____

1. Does proposed Insured have existing life insurance policies or annuity contracts?.....☐ YES ☐ NO
2. Will this insurance replace or change any other insurance policies or annuity contracts? .....☐ YES ☐ NO

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

Please read each question carefully and answer truthfully before signing application.

If the applicant answers YES to any question in Part 1, DO NOT PROCEED with the application.

Part 1

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

If the applicant answers YES to 1 or more questions in Part 2, he/she will be considered for the MWL Plan only.

Part 2

To the best of your knowledge and belief, within the last 2 years have you 1) had, 2) been diagnosed for, 3) had or have any new symptoms for, or 4) awaiting surgery, medical tests or test results for:

	YES	NO
1. Heart attack, irregular heartbeat, aneurysm, any condition leading to stroke, angioplasty or bypass surgery, cardiomyopathy, cardiac defibrillator, heart valve surgery, cerebrovascular insufficiency or blockage?	☐	☐
2. Internal cancer, melanoma, leukemia, sickle cell anemia, renal insufficiency or failure, kidney disease (excluding passed kidney stones), liver disease including cirrhosis; chronic pancreatitis, Hodgkin's Disease, lymphoma, chronic lung disease including emphysema?	☐	☐
3. Paralysis, Parkinson's, Grand Mal epilepsy, lupus or connective tissue disorder, organic brain disorder or suffer from mental retardation?	☐	☐
4. Schizophrenia, psychosis or suicidal thoughts or attempts, including hospitalization for major depression?	☐	☐
5. Alcoholism, drug abuse, narcotic addiction, or been convicted of felony?	☐	☐
6. Are you currently using a wheelchair or walker on a permanent basis?	☐	☐
7. Within the last one year, have you had an application for life insurance declined or refused for any reason?	☐	☐

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

_____

_____

_____

_____

_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

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

X_____ _____ _____
Signature of Proposed Insured | Date | City/State

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

****

Agent Statement:

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

X_____ _____ _____
Printed Agent's Name | Agent's Signature | Agent's Number

LBL-SIM-APP-0911

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

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

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

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

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

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

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

By _____ _____
Agent | Date

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

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

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

I understand that:

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

This authorization is valid from the date signed for duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of LIBERTY BANKERS LIFE INSURANCE COMPANY, P.O. Box 224 Brownwood, Texas 76804-0224. *I may inspect or copy any information used or disclosed under this authorization, if signed*.

Proposed Insured (Please print)	Signature of Proposed Insured (or parent if Proposed Insured is under age 16)
Date	Date of Birth
Additional Proposed Insured (Please print)	Signature of Additional Person Proposed for Insurance
	Date of Birth
	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other _____(Circle one)

LBL-SIM-APP-0911

This Notice Must be Given to Proposed Insured

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

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

Liberty Bankers Life
Insurance Company

PO Box 224 Brownwood, TX 76804-0224
1-888-525-4467 ● FAX 1-888-525-5002 ● E-Mail: newbiz@lbladmin.com

APPLICATION PART I

1. Primary Proposed Insured (Please print full name)			6. Date of Birth Month Day Year	7. Birth Place (State or Country)
2. Address (Street)			8. Age	9. State of Issue & Drivers Lic. #
City State Zip Code			10. Occupation	11. Employer
3. Sex ☐ M ☐ F	4. Soc. Sec. No.	5. Home Phone No. ( ) -	12. Annual Income $	13. Net Worth $

COVERAGE DETAILS

14. Plan Name	15. Amount	16. Benefits/Riders
	$	☐ Child Term Rider ☐ Grandchild Rider* ☐ ALBR **(*Supplemental App must be submitted for GC rider)** ☐ AD&D $_____ ☐ WP ☐ Other _____

17. Child(ren) Rider

Full Name	Date of Birth	Age	Sex	Amount	Relationship	Height	Weight

18. Owner (if other than Primary Proposed Insured)
Name_____ Address_____
Relationship_____ Social Security No._____

19. Beneficiary

Primary _____ Full Name _____ Relationship

Contingent _____ Full Name _____ Relationship

20. Premium Amount: _____

Premium Mode:
☐ Monthly Bank Draft
Draft Day:_____
☐ Check here to draft first premium
☐ Monthly List Bill ☐ Bi-Weekly
☐ Payroll Deduction ☐ Quarterly
☐ Semi-Annual ☐ Annual

	YES	NO
21. Existing Life Insurance or annuity contracts?	☐	☐
Is replacement of existing insurance involved in this application?	☐	☐
If yes: Have you submitted the appropriate replacement forms?	☐	☐

Name of Company	Date of Issue	Life Amount	Purpose Business/Personal	Accidental Death Benefit Amount	Replacement YES	Replacement NO
					☐	☐
					☐	☐
					☐	☐

(If there is additional insurance beyond those listed, please list on a separate sheet)

Please provide details to "Yes" answers in Remarks Section

	YES	NO
22. Has Primary Proposed Insured used tobacco in any form in the past 12 months?	☐	☐
23. Has any Proposed Insured within the past 5 years		
a) Been charged with a driving while impaired (alcohol, drug, other) violation, had a drivers license revoked or suspended or within the last 24 months received 3 or more citations for moving traffic violations?	☐	☐
b) Had an application for insurance declined, rated, or postponed?	☐	☐
c) Flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so?	☐	☐
d) Engaged in parachuting, racing or other hazardous sport or intend to do so?	☐	☐
e) Used intravenous drugs, cocaine, barbiturates, hallucinogens, sought advice or treatment for alcohol or drug use?	☐	☐
24. Does any Proposed Insured intend to reside outside the U.S.?	☐	☐
25. Has any Proposed Insured ever been convicted of a felony or been incarcerated?	☐	☐

26. A) Primary Proposed Insured:

Height	Weight	Change in Past Year?	Cause of Weight Gain/Loss
_____	_____	_____Lbs. ☐ Gain ☐ Loss	

B) Name and Address of personal doctor?_____

C) Date and reason of last doctor visit, include any treatment given, medication prescribed, and results of visit._____

_____

27. Has any Proposed Life Insured, ever had, or been told they had, or received treatment or advice for:

	YES	NO
a) abnormal or high blood pressure, coronary artery disease or any other disorder or disease of the heart, blood vessels or cardiovascular system?	☐	☐
b) cancer, tumor, or any other growth or malignancy?	☐	☐
c) diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder?	☐	☐
d) any nose, throat, lung, or any other respiratory disorder?	☐	☐
e) any disorder of the stomach, intestines, rectum, liver, or pancreas?	☐	☐
f) any injury to or disease of the bones, muscles, joints, eyes, or skin?	☐	☐
g) epilepsy, seizures, brain disorder, or any other disease or disorder of the nervous system?	☐	☐
h) anxiety, depression, or an emotional, behavioral, mental or nervous disorder?	☐	☐
i) any disease or disorder of the kidney, bladder, or genital organs or system?	☐	☐
j) AIDS (acquired immune deficiency syndrome), positive HIV test, or any other immunological disorder?	☐	☐
28 Other than as stated above, has any Proposed Life Insured, within the past 5 years:		
a) Consulted, received treatment or advice from, been prescribed medication by any other medical advisor?	☐	☐
b) Had any abnormal diagnostic tests?	☐	☐
c) Been aware of any symptoms for which a medical advisor has not yet been consulted?	☐	☐
d) Used a wheelchair or walker on a permanent basis?	☐	☐
29. Has any of Proposed Life Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, stroke, or any other hereditary disease?	☐	☐

(If "Yes", indicate family member, illness, age at onset of illness and, if applicable, age at death).

30. REMARKS **(Explain "Yes" answers to Questions 22-29)**

Name of Person(s)	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

PROPOSED INSURED'S NAME IN FULL **APPLICATION PART 3**

AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT –LIBERTY BANKERS LIFE INSURANCE COMPANY

I, the Primary Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereafter

AGREE to the following.

(a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.

(b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is Delivered while the health of any proposed insured continues, without material change, to be as represented in this application.

(c) No agent has authority to waive any answer or otherwise modify this application or to bind Liberty Bankers Life Insurance Company, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this Application.

(d) $_____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

AUTHORIZE any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance or Reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or any other organization, Institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, Treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about pharmacy prescription drugs, drugs, or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or Organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully Required or as I may further authorize. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 30 months from the date shown below. I know that I or my representative may request a copy of this authorization.

ACKNOWLEDGE receipt of the following notices

(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and

(b) MIB Pre-Notice

Signed at _____, _____ _____

City State Date

X)_____ X)_____

SIGNATURE OF PRIMARY PROPOSED INSURED (IF AGE 16 OR OVER) OR PARENT OR GUARDIAN (JUVENILE APPLICATIONS)

SIGNATURE OF OWNER & RELATIONSHIP (IF OTHER THAN PRIMARY PROPOSED INSURED)

_____ X) _____

AGENT'S NAME (Printed, typed or stamped) AGENT'S SIGNATURE

A 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 may be guilty of a crime and subject to fines and confinement in prison.

LBL-WL-APP (0811)

LIBERTY BANKERS LIFE INSURANCE COMPANY

CONDITIONAL RECEIPT

TERMS AND CONDITIONS - coverage issued bearing the date of this receipt will become effective on the date of the application or last medical examination, whichever is later. Coverage will be provided when the following conditions are met.

1. The application and required information is received at our Home Office.
2. All persons proposed for coverage are insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid in cash on the date of application. The maximum amount of life insurance, including accidental death, which will become effective under this receipt, cannot exceed $100,000. This includes any previously pending insurance.

If the Policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first premium must be paid. If the application is declined or not approved within sixty days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

LIBERTY BANKERS LIFE INSURANCE COMPANY

LIFE Plan _____ **Amount $**_____

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

By_____ _____ 20____

Representing Company Date

AGENT'S REPORT

1. Agent Checklist (Provide details in Additional Remarks Section below) **YES** **NO**

A. Did you give the applicant a copy of the Privacy Notice and other disclosure information? ☐ ☐

B. Are you related to the Proposed Insured? ☐ ☐

C. Was this application taken in person? ☐ ☐

D. Do you know anything not disclosed which might affect the underwriting of this risk? ☐ ☐

E. Is there another application currently pending or being submitted to any other life insurance company? ☐ ☐

F. Has any Proposed Insured applied elsewhere for any insurance coverage within the past 6 months? ☐ ☐

G. Does the Proposed Insured have any existing life insurance policies or annuity contracts? ☐ ☐

H. Is replacement of existing insurance involved in this application? If yes: Have you submitted the appropriate replacement forms? ☐ ☐

2. Financial and Medical Requirement Information: **YES** **NO**

A. Have you informed the applicant that he/she may be called for an appointment? ☐ ☐

3. Information for Business Insurance (e.g., Buy/Sell, Split Dollar, Key Person, etc.) **YES** **NO**

A. Is this insurance part of a split dollar agreement? ☐ ☐

B. The business operates as a:

☐ Regular Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship

C. What is the value of the business? $_____

D. What percentage does the Proposed Insured own or control? _____%

E. Are other key individuals applying? If yes, indicate name of each person. If no, for what reason? ☐ ☐
(indicate below) _____

4. Additional Remarks

_____

I certify I have accurately recorded all information given by the Proposed Insured and my statements on this Agent's Report are correct to the best of my knowledge. I claim full credit for this application unless other instructions are given below.

Date _____ **Agency** _____ **Code** _____

Agent's Name Signature X)_____ **Code** _____

Agent's Name Signature X)_____ **Code** _____

LBL-WL-APP (0811)

NOTICE OF INFORMATION PRACTICES **This Notice Must be Given to Proposed Insured**

(Including Medical Information Bureau Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or otherwise with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. **LIBERTY BANKERS LIFE INSURANCE COMPANY** or its Reinsurer may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member Company for life or health insurance coverage, or a claim for benefits is submitted to such a Company, the Bureau, upon request, will supply such Company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts, 02184, telephone 1-866-692-6901, web address: www.mib.com.

LIBERTY BANKERS LIFE INSURANCE COMPANY, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Liberty Bankers Life
Insurance Company

Application for Life Insurance

PO Box 5147 Springfield, IL 62705 1-877-603-0065 FAX 866-505-9377 E-Mail: www.LBLHSApp@utgins.com

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

Proposed Insured (First Name, Initial, Last Name)

_____

State of Birth _____ Country of Birth _____

Date of Birth _____ Current Age _____

Sex _____ Height _____ Weight _____

Social Security No. _____

Street Address _____

City, State, Zip _____ _____ _____

Home/Cell Phone _____

Work Phone: _____

E-Mail Address _____

Occupation _____

1. Have you used tobacco in any form in the past 12 months? ..... ☐ YES ☐ NO
2. Are you a US Citizen including resident alien? ☐ YES ☐ NO
   If No, please explain type of visa or work permit:_____
   _____

OWNER of Policy (if other than Proposed Insured)

_____

Relationship _____

Social Security No._____

Street Address _____

City, State, Zip _____ _____ _____

Home/Cell Phone_____

E-Mail _____

Plan Applied For: _____

Face Amount $_____

Benefits/Riders

☐ **Child Rider # of Units _____**

☐ **Family Income Benefit Rider # of Units _____**

☐ **ADD & CC Rider Benefit Amount $_____**

☐ **Waiver of Premium Rider**
Premium Collected $_____

Premium Mode:

☐ Agent Billed

☐ Monthly Bank Draft

Draft Day:_____

☐ Monthly ☐ Quarterly

☐ Semi-Annual ☐ Annual

Primary Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

Contingent Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

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

Full Name	Date of Birth	Age	Sex	Amount	Relationship	Height	Weight

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

Part 1

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

Part 2

To the best of your knowledge and belief, within the last 3 years have you or any Proposed Insured 1) had, 2) been diagnosed for, 3) had or have any new symptoms for, or 4) awaiting surgery, medical tests or test results for:

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

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

_____

_____

_____

_____

1. Does any Proposed Insured have existing life insurance policies or annuity contracts? ..... ☐ YES ☐ NO
2. Will this insurance replace or change any other insurance policies or annuity contracts? ..... ☐ YES ☐ NO

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

_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

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

X_____ _____ _____
Signature of Proposed Insured | Date | City/State

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

****

Agent Statement:

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

X_____ _____ _____
Printed Agent's Name | Agent's Signature | Agent's Number

LBL-HS-APP-0911

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

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

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

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

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

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

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

By _____ _____
Agent | Date

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

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

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

I understand that:

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

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

Proposed Insured (Please print)	Signature of Proposed Insured (or parent if Proposed Insured is under age 16)
Date	Date of Birth
Additional Proposed Insured (Please print)	Signature of Additional Person Proposed for Insurance
	Date of Birth
	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other _____(Circle one)

LBL-HS-APP-0911

This Notice Must be Given to Proposed Insured

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

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

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

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

AR CERTIFICIATION.pdf

Readability Certification.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: N/A for this filing.

Comments:

Item Status: **Status Date:**

Bypassed - Item: Life & Annuity - Acturial Memo

Bypass Reason: N/A for this filing.

Comments:

CERTIFICIATION

Company Name: Liberty Bankers Life Insurance Company

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

_____

Chad Leiding
Vice President Compliance

9/20/11

_____

Date

READABILITY CERTIFICATION

COMPANY NAME **Liberty Bankers Life Insurance Company** NAIC CO# 68543

FORM NUMBER	FLESCH SCORE
LBL-SIM-APP-0911	* 44.8
LBL-WL-APP (0811)	* 48.8
LBL-HS-APP-0911	*44.8

* scored with policy

Signature of Insurance Company Officer

Vice President Compliance
Typed Name and Title

September 13, 2011
Date

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/27/2011	Form	SIMPL Policy Application	10/05/2011	CLIC-SIM-APP-0911-GENERIC.pdf (Superceded)
09/27/2011	Form	Full Policy Application	10/05/2011	CLIC-WL-APP (0811)-Generic.pdf (Superceded)
09/27/2011	Form	Home Service Policy Application	10/05/2011	CLIC-HS-APP-0911-Generic.pdf (Superceded)

The Capitol Life Insurance Company

Application for "Simplified Issue Market" Use with SIMPL/MWL

P.O. Box 224 Brownwood, Texas 1-888-525-4467 ● FAX 1-888-525-5002 ● E-Mail: newbiz@lbladmin.com

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

Proposed Insured (First Name, Initial, Last Name)

_____

State of Birth _____ Country of Birth _____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

Social Security No. _____

Street Address _____

City, State, Zip _____ _____ _____

Home/Cell Phone _____

Work Phone: _____

E-Mail Address _____

Occupation _____

1. Have you used tobacco in any form in the past 12 months? ..... ☐ YES ☐ NO
2. Are you a US Citizen including resident alien? ☐ YES ☐ NO
   If No, please explain type of visa or work permit:_____
   _____

Plan Applied For: ☐ SIMPL ☐ MWL
☐ OTHER_____

Classification: ☐ Tobacco ☐ Non-Tobacco

Face Amount $_____

Premium Amount $_____

Amount paid with application $_____

Premium Mode:

☐ Monthly Bank Draft
Draft Day:_____

☐ Check here to draft first premium

☐ Monthly List Bill ☐ Bi-Weekly

☐ Payroll Deduction ☐ Quarterly

☐ Semi-Annual ☐ Annual

OWNER of Policy (if other than Proposed Insured)

_____

Relationship _____

Social Security No._____

Street Address _____

City, State, Zip _____ _____ _____

Home/Cell Phone_____

E-Mail _____

Primary Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone_____

E-Mail _____

Contingent Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone_____

E-Mail _____

1. Does proposed Insured have existing life insurance policies or annuity contracts?.....☐ YES ☐ NO
2. Will this insurance replace or change any other insurance policies or annuity contracts? .....☐ YES ☐ NO

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

Please read each question carefully and answer truthfully before signing application.

If the applicant answers YES to any question in Part 1, DO NOT PROCEED with the application.

Part 1

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

If the applicant answers YES to 1 or more questions in Part 2, he/she will be considered for the MWL Plan only.

Part 2

To the best of your knowledge and belief, within the last 2 years have you 1) had, 2) been diagnosed for, 3) had or have any new symptoms for, or 4) awaiting surgery, medical tests or test results for:

	YES	NO
1. Heart attack, irregular heartbeat, aneurysm, any condition leading to angioplasty or bypass surgery, cardiomyopathy, cardiac defibrillator, heart valve surgery, stroke, cerebrovascular insufficiency or blockage?	☐	☐
2. Internal cancer, melanoma, leukemia, sickle cell anemia, renal insufficiency or failure, kidney disease (excluding passed kidney stones), liver disease including cirrhosis; chronic pancreatitis, Hodgkin's Disease, lymphoma, chronic lung disease including emphysema?	☐	☐
3. Paralysis, Parkinson's, Grand Mal epilepsy, multiple sclerosis, lupus or connective tissue disorder, organic brain disorder or suffer from mental retardation?	☐	☐
4. Schizophrenia, psychosis or suicidal thoughts or attempts, including hospitalization for major depression?	☐	☐
5. Alcoholism, drug abuse, narcotic addiction, or been convicted of felony?	☐	☐
6. Are you currently using a wheelchair or walker on a permanent basis?	☐	☐
7. Within the last one year, have you had an application for life insurance declined or refused for any reason?	☐	☐

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

_____

_____

_____

_____

_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

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

X_____ _____ _____
Signature of Proposed Insured | Date | City/State

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

****

Agent Statement:

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

X_____ _____ _____
Printed Agent's Name | Agent's Signature | Agent's Number

CLIC-SIM-APP-0911

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

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

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

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

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

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

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

By _____ _____
Agent | Date

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

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

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

I understand that:

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

This authorization is valid from the date signed for duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of THE CAPITOL LIFE INSURANCE COMPANY, P.O. Box 224 Brownwood, Texas 76804-0224. . *I may inspect or copy any information used or disclosed under this authorization, if signed*.

Proposed Insured (Please print)	Signature of Proposed Insured (or parent if Proposed Insured is under age 16)
Date	Date of Birth
Additional Proposed Insured (Please print)	Signature of Additional Person Proposed for Insurance
	Date of Birth
	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other _____(Circle one)

CLIC-SIM-APP-0911

This Notice Must be Given to Proposed Insured

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

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

The Capitol Life Insurance Company

PO Box 224 Brownwood, TX 76804-0224
1-888-525-4467 ● FAX 1-888-525-5002 ● E-Mail: newbiz@lbladmin.com

APPLICATION PART I

1. Primary Proposed Insured (Please print full name)			6. Date of Birth Month Day Year	7. Birth Place (State or Country)
2. Address (Street)			8. Age	9. State of Issue & Drivers Lic. #
City	State	Zip Code	10. Occupation	11. Employer
3. Sex ☐ M ☐ F	4. Soc. Sec. No.	5. Home Phone No. ( ) -	12. Annual Income $	13. Net Worth $

COVERAGE DETAILS

14. Plan Name	15. Amount	16. Benefits/Riders
	$	☐ Child Term Rider ☐ Grandchild Rider* ☐ ALBR **(*Supplemental App must be submitted for GC rider)** ☐ AD&D $_____ ☐ WP ☐ Other _____

17. Child(ren) Rider

Full Name	Date of Birth	Age	Sex	Amount	Relationship	Height	Weight

18. Owner (if other than Primary Proposed Insured)

Name_____ Address_____

Relationship_____ Social Security No._____

19. Beneficiary

Primary _____ Full Name _____ Relationship

Contingent _____ Full Name _____ Relationship

20. Premium Amount: _____

Premium Mode:

☐ Monthly Bank Draft
Draft Day:_____

☐ Check here to draft first premium

☐ Monthly List Bill ☐ Bi-Weekly

☐ Payroll Deduction ☐ Quarterly

☐ Semi-Annual ☐ Annual

	YES	NO
21. Existing Life Insurance or annuity contracts?	☐	☐
Is replacement of existing insurance involved in this application?	☐	☐
If yes: Have you submitted the appropriate replacement forms?	☐	☐

Name of Company	Date of Issue	Life Amount	Purpose Business/Personal	Accidental Death Benefit Amount	Replacement YES	Replacement NO
					☐	☐
					☐	☐
					☐	☐

(If there is additional insurance beyond those listed, please list on a separate sheet)

Please provide details to "Yes" answers in Remarks Section

	YES	NO
22. Has Primary Proposed Insured used tobacco in any form in the past 12 months??	☐	☐
23. Has any Proposed Insured within the past 5 years		
a) Been charged with a driving while impaired (alcohol, drug, other) violation, had a drivers license revoked or suspended or within the last 24 months received 3 or more citations for moving traffic violations?	☐	☐
b) Had an application for insurance declined, rated, or postponed?	☐	☐
c) Flown as a pilot, student pilot or crew member of any aircraft or have intentions to do so?	☐	☐
d) Engaged in parachuting, racing or other hazardous sport or intend to do so?	☐	☐
e) Used intravenous drugs, cocaine, barbiturates, hallucinogens, sought advice or treatment for alcohol or drug use?	☐	☐
24. Does any Proposed Insured intend to reside outside the U.S.?	☐	☐
25. Has any Proposed Insured ever been convicted of a felony or been incarcerated?	☐	☐

26. A) Primary Proposed Insured:

Height	Weight	Change in Past Year?	Cause of Weight Gain/Loss
_____	_____	_____Lbs. ☐ Gain ☐ Loss	

B) Name and Address of personal doctor?_____

C) Date and reason of last doctor visit, include any treatment given, medication prescribed, and results of visit._____

_____

27. Has any Proposed Life Insured ever had, or been told they had, or received treatment or advice for:

	YES	NO
a) abnormal or high blood pressure, coronary artery disease or any other disorder or disease of the heart, blood vessels or cardiovascular system?	☐	☐
b) cancer, tumor, or any other growth or malignancy?	☐	☐
c) diabetes, thyroid disorder, anemia, hepatitis, or any other blood or glandular disorder?	☐	☐
d) any nose, throat, lung, or any other respiratory disorder?	☐	☐
e) any disorder of the stomach, intestines, rectum, liver, or pancreas?	☐	☐
f) any injury to or disease of the bones, muscles, joints, eyes, or skin?	☐	☐
g) epilepsy, seizures, brain disorder, or any other disease or disorder of the nervous system?	☐	☐
h) anxiety, depression, or an emotional, behavioral, mental or nervous disorder?	☐	☐
i) any disease or disorder of the kidney, bladder, or genital organs or system?	☐	☐
j) AIDS (acquired immune deficiency syndrome), positive HIV test, or any other immunological disorder?	☐	☐
28 Other than as stated above, has any Proposed Life Insured within the past 5 years:		
a) Consulted, received treatment or advice from, been prescribed medication by any other medical advisor?	☐	☐
b) Had any abnormal diagnostic tests?	☐	☐
c) Been aware of any symptoms for which a medical advisor has not yet been consulted?	☐	☐
d) Used a wheelchair or walker on a permanent basis?	☐	☐
29. Has any of Proposed Life Insured's parents and/or siblings had heart disease, kidney disease, diabetes, cancer, stroke, or any other hereditary disease?	☐	☐

(If "Yes", indicate family member, illness, age at onset of illness and, if applicable, age at death).

30. REMARKS **(Explain "Yes" answers to Questions 22-29)**

Name of Person(s)	Illness	Date & Duration	Treatment & Results	Doctors & Hospitals

PROPOSED INSURED'S NAME IN FULL **APPLICATION PART 3**

AGREEMENT - AUTHORIZATION - ACKNOWLEDGMENT –THE CAPITOL LIFE INSURANCE COMPANY

I, the Primary Proposed Insured (and any Spouse or Owner signing below), by my signature set forth hereafter

AGREE to the following.

(a) All Statements and answers in this application are complete and true to the best of my knowledge and belief.

(b) Except as stated in the Conditional Receipt, no insurance will take effect unless the first full premium is paid and a policy is Delivered while the health of any proposed insured continues, without material change, to be as represented in this application.

(c) No agent has authority to waive any answer or otherwise modify this application or to bind The Capitol Life Insurance Company, hereinafter called "Company", in any way by making any promise or representation which is not set out in writing in this Application.

(d) $_____ has been deposited toward payment of the first premium on the policy applied for. The terms of the Conditional Receipt received for that premium deposit are accepted.

AUTHORIZE any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance or Reinsuring company, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or any other organization, Institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, Treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about pharmacy prescription drugs, drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or Organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully Required or as I may further authorize. As to this Authorization, I agree that a photographic copy will be as valid as the original and that it will be valid for 30 months from the date shown below. I know that I or my representative may request a copy of this authorization.

ACKNOWLEDGE receipt of the following notices

(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and

(b) MIB Pre-Notice

Signed at _____, _____ _____

City State Date

X)_____ X)_____

SIGNATURE OF PRIMARY PROPOSED INSURED (IF AGE 16 OR OVER) OR PARENT OR GUARDIAN (JUVENILE APPLICATIONS)

SIGNATURE OF OWNER & RELATIONSHIP (IF OTHER THAN PRIMARY PROPOSED INSURED)

_____ X) _____

AGENT'S NAME (Printed, typed or stamped) AGENT'S SIGNATURE

A 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 may be guilty of a crime and subject to fines and confinement in prison.

CLIC-WL-APP (0811)

THE CAPITOL LIFE INSURANCE COMPANY

CONDITIONAL RECEIPT

TERMS AND CONDITIONS - coverage issued bearing the date of this receipt will become effective on the date of the application or last medical examination, whichever is later. Coverage will be provided when the following conditions are met.

1. The application and required information is received at our Home Office.
2. All persons proposed for coverage are insurable at standard rates exactly as applied for according to the rules and practices of the Company at its Home Office.
3. The full first premium is paid in cash on the date of application. The maximum amount of life insurance, including accidental death, which will become effective under this receipt, cannot exceed $100,000. This includes any previously pending insurance.

If the Policy is not issued exactly as applied for, it will become effective when it is delivered to and accepted by the applicant. Upon delivery and acceptance, the first premium must be paid. If the application is declined or not approved within sixty days of its completion, no insurance will have been in force. Any premium paid will be returned. No agent of our Company has the authority to change or modify any of the provisions of this receipt.

THE CAPITOL LIFE INSURANCE COMPANY

LIFE Plan _____ **Amount $**_____

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

By_____ _____ 20____

Representing Company Date

AGENT'S REPORT

1. Agent Checklist (Provide details in Additional Remarks Section below)	YES	NO
A. Did you give the applicant a copy of the Privacy Notice and other disclosure information?	☐	☐
B. Are you related to the Proposed Insured?	☐	☐
C. Was this application taken in person?	☐	☐
D. Do you know anything not disclosed which might affect the underwriting of this risk?	☐	☐
E. Is there another application currently pending or being submitted to any other life insurance company?	☐	☐
F. Has any Proposed Insured applied elsewhere for any insurance coverage within the past 6 months?	☐	☐
G. Does the Proposed Insured have any existing life insurance policies or annuity contracts?	☐	☐
H. Is replacement of existing insurance involved in this application? If yes: Have you submitted the appropriate replacement forms?	☐	☐

2. Financial and Medical Requirement Information:	YES	NO
A. Have you informed the applicant that he/she may be called for an appointment?	☐	☐

3. Information for Business Insurance (e.g., Buy/Sell, Split Dollar, Key Person, etc.)	YES	NO
A. Is this insurance part of a split dollar agreement?	☐	☐

B. The business operates as a:

☐ Regular Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietorship

C. What is the value of the business? $_____

D. What percentage does the Proposed Insured own or control? _____%

E. Are other key individuals applying? If yes, indicate name of each person. If no, for what reason? ☐ ☐
(indicate below) _____

4. Additional Remarks

_____

I certify I have accurately recorded all information given by the Proposed Insured and my statements on this Agent's Report are correct to the best of my knowledge. I claim full credit for this application unless other instructions are given below.

Date _____ **Agency** _____ **Code** _____

Agent's Name Signature X)_____ **Code** _____

Agent's Name Signature X)_____ **Code** _____

CLIC-WL-APP (0811)

NOTICE OF INFORMATION PRACTICES **This Notice Must be Given to Proposed Insured**

(Including Medical Information Bureau Notice, Fair Credit Report Act of 1970, and Public Law 91-508)

In making this application for insurance it is understood that an investigative report may be made whereby information is obtained through personal interviews with third parties, such as family members, business associates, financial sources, friends, neighbors, or otherwise with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living, whichever may be applicable. You have the right to make a written request within a reasonable period of time for a complete accurate disclosure of additional information concerning the nature and scope of the investigation.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. **THE CAPITOL LIFE INSURANCE COMPANY** or its Reinsurer may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member Company for life or health insurance coverage, or a claim for benefits is submitted to such a Company, the Bureau, upon request, will supply such Company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184, telephone 1-866-692-6901, web address: www.mib.com.

THE CAPITOL LIFE INSURANCE COMPANY, or its Reinsurer(s), may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

The Capitol Life Insurance Company

Application for Life Insurance

PO Box 224 – Brownwood, TX 76804-0224 ● 1-888-525-4467 ● FAX 1-888-525-5002 ● E-Mail: newbiz@lbladmin.com

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

Proposed Insured (First Name, Initial, Last Name)

_____

State of Birth _____ Country of Birth _____

Date of Birth _____ Current Age _____

Sex _____ Height _____ Weight _____

Social Security No. _____

Street Address _____

City, State, Zip _____ _____ _____

Home/Cell Phone _____

Work Phone: _____

E-Mail Address _____

Occupation _____

1. Have you used tobacco in any form in the past 12 months? ..... ☐ YES ☐ NO
2. Are you a US Citizen including resident alien? ☐ YES ☐ NO
   If No, please explain type of visa or work permit:_____
   _____

OWNER of Policy (if other than Proposed Insured)

_____

Relationship _____

Social Security No._____

Street Address _____

City, State, Zip _____ _____ _____

Home/Cell Phone_____

E-Mail _____

Plan Applied For: _____

Face Amount $_____

Benefits/Riders

☐ **Child Rider # of Units _____**

☐ **Family Income Benefit Rider # of Units _____**

☐ **ADD & CC Rider Benefit Amount $_____**

☐ **Waiver of Premium Rider**

Premium Collected $_____

Premium Mode:

☐ Agent Billed

☐ Monthly Bank Draft

Draft Day:_____

☐ Monthly ☐ Quarterly

☐ Semi-Annual ☐ Annual

Primary Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

Contingent Beneficiary _____

Relationship _____

Street Address _____

Home/Cell Phone _____

E-Mail _____

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

Full Name	Date of Birth	Age	Sex	Amount	Relationship	Height	Weight

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

Part 1

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

Part 2

To the best of your knowledge and belief, Within the last 2 years have you: 1) had, 2) been diagnosed for, 3) had or have any new symptoms for, or 4) awaiting surgery, medical tests or test results for:

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

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

_____

_____

_____

_____

1. Does any Proposed Insured have existing life insurance policies or annuity contracts? ☐ YES ☐ NO
2. Will this insurance replace or change any other insurance policies or annuity contracts? ☐ YES ☐ NO

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

_____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

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

X_____ _____ _____
Signature of Proposed Insured | Date | City/State

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

****

Agent Statement:

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

X_____ _____ _____
Printed Agent's Name | Agent's Signature | Agent's Number

CLIC-HS-APP-0911

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

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

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

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

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

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

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

By _____ _____
Agent | Date

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

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

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

I understand that:

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

This authorization is valid from the date signed for duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of THE CAPITOL LIFE INSURANCE COMPANY, P. O. Box 224, Brownwood, TX 76804. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Proposed Insured (Please print)	Signature of Proposed Insured (or parent if Proposed Insured is under age 16)
Date	Date of Birth
Additional Proposed Insured (Please print)	Signature of Additional Person Proposed for Insurance
	Date of Birth
	Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other _____(Circle one)

CLIC-HS-APP-0911

This Notice Must be Given to Proposed Insured

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

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

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