

Application for Medicare Supplement Insurance

Arizona

032218

Liberty Bankers Life Insurance Company

Speed up the processing by double checking the following:

- Applicant's personal information completed (DOB, Gender, SSN, Medicare number/dates)
- All dates completed
 (Effective dates, signature dates)
- Replacement form completed
 (Termination reason marked, signed & dated)
- **Premium and payment information completed** (Modal Premium listed, Bank information complete)
- **Prior coverage information completed** (Carrier, plan, start & end dates)

Important Notice:

EFT Premium Payments will be drafted upon issuance

Liberty Bankers Life Insurance Company Administrative Office PO Box 15357 • Clearwater, FL 33766-5357 Fax 1-855-493-9242 • Toll-free telephone 844-770-2400 • www.libertybankerslife.com

Writing Agent #

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant. Use Section 9 if additional space is needed.

SECTION 1. PLAN & PREMIUM PAYMENT INFORMATION - TO BE COMPLETED BY PRODUCER

NOTE: If more than 1 applicant, complete Applicant B sections.

Applicant A	Applicant B
Medicare Supplement Plan Applied for:	Medicare Supplement Plan Applied for:
Requested Effective Date//	Requested Effective Date//
Mail Policy To:	Mail Policy To: Insured Agent
Calculated Premium (include app fee; HHD)	Calculated Premium (include app fee; HHD)
\$\$+\$=\$	\$\$+\$=\$
premium HHD app fee total	premium HHD app fee total
Select Premium Payment Option:	Select Premium Payment Option:
ACH Annual Annual direct	ACH Annual Annual direct
□ ACH Semi-annual □ Semi-annual direct	ACH Semi-annual Semi-annual direct
ACH Quarterly Quarterly direct	ACH Quarterly Quarterly direct
\Box ACH Monthly (direct monthly is not available)	\Box ACH Monthly (direct monthly is not available)
SECTION 2. APPLICANT INFORMATION – PLEASE ANSW	ER ALL QUESTIONS COMPLETELY
Applicant A	Applicant B
Name (First/Middle/Last) should match Medicare health ins. card.	Name (First/Middle/Last) should match Medicare health ins. card.
Physical Address	Physical Address
City	City
State ZIP+	State ZIP+
Mailing Address (if different from physical address)	Mailing Address (if different from physical address)
City	City
State ZIP+	State ZIP+

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SECTION 2. APPLICANT INFORMATION, CONTINUED – PLEASE ANSWER ALL QUESTIONS COMPLETELY		
Applicant B		
Secondary Residence Zip:+		
Home Phone No. ()		
Best Time to Contact:		
E-mail Address		
Current Age Date of Birth// mo / day / yr		
□ Male □ Female State of Birth		
Height: feet inches Weight: pounds		
In the past 12 months, have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes?		
Social Security No		
Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage and the Notice of Information Practices?		
MEDICARE (1-800-633-4227) ANNO OF BUSING ARE (1-800-633-4227) MICONING AND		
Medicare Health Insurance Card Claim Number (if known)		
To the Best of your Knowledge: 1. Did you turn age 65 in the last 6 months? Yes No 2. Did you enroll in Medicare Part B in the last 6 months? Yes No		

SECTION 3: HOUSEHOLD PREMIUM DISCOUNT INFORMATION.				
You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.	Applicant A	Applicant B		
 Do you currently live with your legal spouse, including validly recognized civil union and domestic partners, or do you currently have a household resident (at least one, no more than 3) with whom you have continuously resided for the last 12 months and who is age 18 or older? If you answered "YES" to Question 1 above, please fill out the following information 	□ Yes □ No	□ Yes □ No		
about the household resident, except if both applicants are applying for coverage on this application.				
Name (First/Middle/Last)	L			
Street Address				
City/State/Zip				
Name (First/Middle/Last)				
Street Address				
City/State/Zip				
Name (First/Middle/Last)				
Street Address				
City/State/Zip				

SECTION 4. FOR YOUR PROTECTION, we ask the following questions about insurance policies or certificates you may have.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

	Applicant A	Applicant B
To the Best of Your Knowledge:		
 Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.) 	🗆 Yes 🗌 No	🗆 Yes 🗌 No
 Are you covered for medical assistance through the state Medicaid program?	🗆 Yes 🗌 No	🗆 Yes 🗌 No
(a) Will Medicaid pay your premiums for this Medicare Supplement policy?	🗆 Yes 🛛 No	🗆 Yes 🛛 No
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	🗆 Yes 🛛 No	🗆 Yes 🛛 No
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. If you are still covered under this plan, leave "END" blank	Start // End //	Start // End //
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	🗆 Yes 🗆 No	🗆 Yes 🗆 No
(b) If "YES," have you received a copy of the replacement notice?	🗆 Yes 🛛 No	🗆 Yes 🛛 No
(c) Reason for termination/disenrollment?		
(d) Planned date of termination/disenrollment?	//	//
(e) Was this your first time in this type of Medicare plan?	🗆 Yes 🗆 No	🗆 Yes 🛛 No
(f) Did you drop a Medicare Supplement or Medicare select		
policy/certificate to enroll in this Medicare plan? If "YES,"	🗆 Yes 🛛 No	🗆 Yes 🛛 No
(g) Is your former Medicare Supplement plan or Medicare select policy/certificate still available?	🗆 Yes 🛛 No	🗆 Yes 🛛 No

SECTION 4. FOR YOUR PROT you may have, CONTINUED	ECTION, we ask the following q	uestions about insurance	policies or certificates
		Applicant A	Applicant B
	rte Supplement or Medicare rtificate in force? bany, and what plan do you have?	□ Yes □ No	□ Yes □ No
Арј	olicant A	Appli	cant B
Name of Company		Name of Company	
Plan		Plan	
Effective Date//		Effective Date/	/
	to replace your current Medicare icate with this policy	Applicant A □ Yes □ No	Applicant B □ Yes □ No
	ation date	//	//
	ved a copy of the replacement	🗆 Yes 🛛 No	🗆 Yes 🛛 No
5. Have you had coverage under within the past 63 days?	er any other health insurance	🗆 Yes 🛛 No	🗆 Yes 🛛 No
 (For example, an employer, u Supplement plan) (a) If "YES," with what compa policy/certificate? (List bel 			
Appli	cant A		cant B
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate
		Applicant A	Applicant B
	overage under the other policy/ covered under this plan, leave senrollment?	Start // End //	Start // End //
Applicant A	Applicant B		
 (d) Planned date of termination 6. Producers shall list any other here they have sold to the applicant. (a) List policies/certificates sold 	ealth insurance policies/certificates	//	//
	cant A	Appli	cant B
Name of Company		Name of Company	
Description of Benefits		Description of Benefits	
Effective Date of Coverage / /		Effective Date of Coverage / /	
(b) List policies/certificates sold in the past five (5) years which			
Applicant A		Appli	icant B

If you are applying during Open Enrollment or Guaranteed Issue period, SKIP SECTIONS 5 and 6 and GO TO SECTION 7					
SECTION 5. HEALTH QUESTIONS - If either Applicant A or Applicant B answer "Yes" to any of the following questions 1-15, or to <u>any</u> of 16 B, C, D, or E that person is not eligible for Medicare Supplement Coverage.					
	······································		ant A	Applica	ant B
treatment or therapy that I	nas not been performed?	□ Yes	🗆 No	🗆 Yes	🗆 No
2. Have you been advised by the next 12 months for ca	y a physician that surgery may be required within taract(s)?	□ Yes	🗆 No		🗆 No
3. Have you been hospitalize	ed two or more times within the last two years?	□ Yes	🗆 No	□ Yes	🗆 No
	zed, bedridden, living in a nursing facility, health care, using a wheelchair or a motorized	□ Yes	🗆 No	🗆 Yes	□ No
5. Have you had an organ tra	ansplant or amputation caused by disease?	□ Yes	🗆 No	□ Yes	🗆 No
	I with emphysema or chronic pulmonary a, or have you been treated with supplemental a pulmonary disorder?	□ Yes	🗆 No	□ Yes	🗆 No
	l with Parkinson's disease, multiple sclerosis, sclerosis), systemic lupus, or myasthenia	□ Yes	🗆 No	□ Yes	□ No
8. Have you been diagnosed any other cognitive disord	I with, Alzheimer's disease, senile dementia or er?	□ Yes	🗆 No	□ Yes	🗆 No
(AIDS), AIDS Related Cor of HIV antibodies, antigen positive screening test suc	I with Acquired Immune Deficiency Syndrome nplex (ARC,) or tested positive for the presence s or the virus with tests consisting of both a ch as enzyme-linked immunoassay (ELISA) and ist such as a Western Blot?	□ Yes	🗆 No	□ Yes	□ No
	have you been treated or been advised by a nt for internal cancer or melanoma?	□ Yes	🗆 No	□ Yes	□ No
	have you been treated or been advised by a nt for chronic kidney disease, cirrhosis, or	□ Yes	□ No	□ Yes	🗆 No
	have you been treated or been advised by a nt for alcoholism, drug abuse, mental or nervous tric hospitalization?	□ Yes	□ No	□ Yes	□ No
physician to have treatme congestive heart failure, e	have you been treated or been advised by a nt for heart attack, coronary artery disease, nlarged heart , heart valve surgery, or heart g use of pacemaker or defibrillator?	□ Yes	□ No	□ Yes	□ No
physician to have treatme	have you been treated or been advised by a nt for stroke, transient ischemic attack (TIA), peripheral vascular disease?	□ Yes	□ No	□ Yes	□ No
physician to have treatme rheumatoid arthritis, or cri	have you been treated or been advised by a nt for osteoporosis with a fracture or fractures, ppling or disabling arthritis?	□ Yes	□ No	□ Yes	□ No
insulin daily or three C. diagnosed with retine D. diagnosed with hear	een: I professional to take more than 50 units of or more medications (insulin and oral)? opathy or neuropathy?	□ Yes □ Yes □ Yes □ Yes □ Yes	s □ No s □ No	□ Yes □ Yes □ Yes □ Yes □ Yes	□ No □ No

SECTION 6. MEDICATION INFORMATION

1. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please provide the details in the following table. Use Section 9 if additional space is needed.

Applicant A (please attach a separate sheet if needed)		Applicant B Yes No (please attach a separate sheet if needed)
	Medication Name (as shown on label)	
/	Date Originally Prescribed	/
	Frequency and Dosage	
	Diagnosis/Condition/Reason	
	Medication Name (as shown on label)	
/	Date Originally Prescribed	/
	Frequency and Dosage	
	Diagnosis/Condition/Reason	
	Medication Name (as shown on label)	
/	Date Originally Prescribed	/
	Frequency and Dosage	
	Diagnosis/Condition/Reason	
	Medication Name (as shown on label)	
/	Date Originally Prescribed	/
	Frequency and Dosage	
	Diagnosis/Condition/Reason	
	Medication Name (as shown on label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition/Reason	

SECTION 7. METHOD OF PAYMENT – PLEASE COMPLETE ALL QUESTIONS

IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal,

THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY

WHEN YOUR POLICY IS ISSUED.

The first withdrawal date may be different from the monthly date selected for renewal premiums. Subsequent premiums will be withdrawn approximately thirty (30) days from the effective date of coverage or on the date specified on this application.

I authorize Liberty Bankers Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes I authorize you, my financial institution, to pay from my account to "Liberty Bankers Life Insurance Company" any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

I would like my automatic mo	nthly withdrawal to come from my (check one below) on the	day (must
be between the 1st and 28th)	of the month:	

Checking

Please attach a voided check

Savings

Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.

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 Payments cannot be postponed from the date selected. Payment from a third party, including any foundation, DATE PAY TO THE ORDER OF 1\$ will not be accepted. • All refunds will be made to the applicant in the event DOLLARS of rejection, incomplete submission, overpayment, cancellation, etc. FOR :000000186: 000000529* 1000 Routing Number Account Number Check Number (9 digits) Financial Institution Name: Phone #: Financial Institution Address:

Transit Routing # (from left side of check)	Account # (from right side of check)
X	X
Authorized Signature as Shown on Account	Authorized Signature as Shown on Account
//	//
Date	Date

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SECTION 8. AUTHORIZATION AND ACKNOWLEDGEMENT

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if
 requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for
 Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent
 policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient
 prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug
 coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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 Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY (LBL) or its reinsurers 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). I also authorize all said sources to give such records or knowledge to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on behalf of LBL. It is understood that LBL's 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 authorize MIB, Inc. to provide any medical or personal information that it has about me to LBL or any MIB-authorized third-party administrator performing underwriting services on LBL's behalf. I also authorize LBL, its reinsurer or authorized third-party administrator, to make a brief report of my protected health information to the MIB, Inc.

I understand that:

• such information will be used by LBL for underwriting and insurability determinations;

• I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain Medicare Supplement 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 a duration of 24 months, except for the disclosure of HIV-related information, which is valid from the date signed for a duration of 180 days. 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 Underwriting Department of LBL, PO Box 15357, Clearwater, FL 33766-5357. I may inspect or copy any information used or disclosed under this authorization, if signed.

Any insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

To the best of my knowledge and belief, I wish to apply for a Medicare Supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by LBL.

Dated at			, on / /	
	City	State	mo / day / yr	Applicant A's Signature
Dated at			, on / /	
	City	State	mo / day / yr	Applicant B's Signature

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SECTION 8. AUTHORIZATION AND ACKNOWLEDGEMENT, CONTINUED

Premium payment information must accompany application.

I certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

PRODUCER NUMBER

(Signature of Licensed Producer)

Х

SECTION 9. FOR ADDITIONAL COMMENTS	
Applicant A (please attach a separate sheet if needed)	Applicant B (please attach a separate sheet if needed)

LIBERTY BANKERS LIFE INSURANCE COMPANY Medicare Supplement Administrative Office: PO Box 15357, Clearwater, FL 33766-5357

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Liberty Bankers Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

□ Additional benefits.

□ No change in benefits, but lower premiums

- **G** Fewer benefits and lower premiums.
- □ Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
- □ My plan has outpatient drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.

Other (please specify) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker or Other Representative

Agent's Printed Name and Address

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Applicant's Signature

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Other (please specify) _____

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Signature of Agent, Broker or Other Representative

Agent's Printed Name and Address

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Applicant's Signature



Administrative Office: P.O. Box 15357 Clearwater, FL 33766-5357

PRODUCER CERTIFICATION

I the undersigned insurance producer certify:

THAT I have taken an application for:

Applicant:	Applicant B:
Medicare Supplement	Medicare Supplement
🗌 Plan A	🗌 Plan A
🗌 Plan F	🗌 Plan F
🗌 Plan G	🗌 Plan G
🗌 Plan N	🗌 Plan N

Offered by Liberty Bankers Life Insurance Company,

to

(Applicant(s)),

THAT I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

Date

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

Signature of Applicant

Signature of Producer

Name of Agency

Address of Producer or Agency

Signature of Applicant B, if applying

Phone Number

Liberty Bankers Life Insurance Company P.O. Box 15357 Clearwater, Florida 33766-5357



Phone: 844-770-2400 Fax: 855-493-9242

Notification regarding the Medical Information Bureau

Information regarding your insurability will be treated as confidential. Liberty Bankers Life or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901.

If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Liberty Bankers, or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

FAIR CREDIT REPORTING ACT NOTICE

With regard to your application, We may request a consumer report or an investigative consumer report. These reports contain information about your character, general reputation, mode of living and health. No adverse underwriting decision will be made based on your sexual orientation. The information may have been obtained through interviews with you, your neighbors, friends and others who know you. Upon request, We will give you the name and address of the consumer reporting agency so that you may request a copy of the report.

Liberty Bankers Life Insurance Company

FAX TRANSMITTAL

FOR USE WITH EFT PREMIUM APPLICATIONS ONLY 1-855-493-9242

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