



Liberty Bankers Life

Insurance Company

**Application for
Medicare Supplement Insurance**

A r i z o n a

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**

Application For: Medicare Supplement Coverage

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 Name	Writing Agent #
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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: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan N	Medicare Supplement Plan Applied for: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan N
Requested Effective Date <u> </u> / <u> </u> / <u> </u> <small style="margin-left: 100px;">mo / day / yr</small>	Requested Effective Date <u> </u> / <u> </u> / <u> </u> <small style="margin-left: 100px;">mo / day / yr</small>
Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent	Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent
Calculated Premium (include app fee; HHD) \$ <u> </u> - \$ <u> </u> + \$ <u> </u> = \$ <u> </u> <small style="margin-left: 20px;">premium HHD app fee total</small>	Calculated Premium (include app fee; HHD) \$ <u> </u> - \$ <u> </u> + \$ <u> </u> = \$ <u> </u> <small style="margin-left: 20px;">premium HHD app fee total</small>
Select Premium Payment Option: <input type="checkbox"/> ACH Annual <input type="checkbox"/> Annual direct <input type="checkbox"/> ACH Semi-annual <input type="checkbox"/> Semi-annual direct <input type="checkbox"/> ACH Quarterly <input type="checkbox"/> Quarterly direct <input type="checkbox"/> ACH Monthly (direct monthly is not available)	Select Premium Payment Option: <input type="checkbox"/> ACH Annual <input type="checkbox"/> Annual direct <input type="checkbox"/> ACH Semi-annual <input type="checkbox"/> Semi-annual direct <input type="checkbox"/> ACH Quarterly <input type="checkbox"/> Quarterly direct <input type="checkbox"/> ACH Monthly (direct monthly is not available)

SECTION 2. APPLICANT INFORMATION – PLEASE ANSWER 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 <u> </u> + <u> </u>	State ZIP <u> </u> + <u> </u>
Mailing Address (if different from physical address)	Mailing Address (if different from physical address)
City	City
State ZIP <u> </u> + <u> </u>	State ZIP <u> </u> + <u> </u>

SECTION 2. APPLICANT INFORMATION, CONTINUED – PLEASE ANSWER ALL QUESTIONS COMPLETELY

Applicant A	Applicant B
Secondary Residence Zip: _____+_____	Secondary Residence Zip: _____+_____
Home Phone No. (_____) _____ - _____ (area code)	Home Phone No. (_____) _____ - _____ (area code)
Best Time to Contact:	Best Time to Contact:
E-mail Address	E-mail Address
Current Age _____ Date of Birth ____/____/____ mo / day / yr	Current Age _____ Date of Birth ____/____/____ mo / day / yr
<input type="checkbox"/> Male <input type="checkbox"/> Female State of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female State of Birth _____
Height: ___ feet ___ inches Weight: _____ pounds	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? <input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 12 months, have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security No. _____ - _____ - _____	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 ? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ? <input type="checkbox"/> Yes <input type="checkbox"/> No...
<p>Please reference your Medicare Card to complete the following questions.</p> <div data-bbox="852 1255 1230 1459" data-label="Image"> </div>	
Medicare Health Insurance Card Claim Number (if known)	Medicare Health Insurance Card Claim Number (if known)
<p>To the Best of your Knowledge:</p> <p>1. Did you turn age 65 in the last 6 months?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Did you enroll in Medicare Part B in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please complete the following: Medicare Part A Effective Date: ____/____/____ Medicare Part B Effective Date: ____/____/____</p>	<p>To the Best of your Knowledge:</p> <p>1. Did you turn age 65 in the last 6 months?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Did you enroll in Medicare Part B in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please complete the following: Medicare Part A Effective Date: ____/____/____ Medicare Part B Effective Date: ____/____/____</p>

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.

1. 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?
2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are applying for coverage on this application.

Applicant A

Yes No

Applicant B

Yes No

Name (First/Middle/Last)

Street Address

City/State/Zip

Name (First/Middle/Last)

Street Address

City/State/Zip

Name (First/Middle/Last)

Street Address

City/State/Zip

Application For: Medicare Supplement Coverage

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
<p>To the Best of Your Knowledge:</p> <p>1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES",</p> <p>(a) Will Medicaid pay your premiums for this Medicare Supplement policy?.....</p> <p>(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?.....</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>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.....</p> <p>(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?.....</p> <p>(b) If "YES," have you received a copy of the replacement notice?.....</p> <p>(c) Reason for termination/disenrollment? _____</p> <p>(d) Planned date of termination/disenrollment? _____</p> <p>(e) Was this your first time in this type of Medicare plan?</p> <p>(f) Did you drop a Medicare Supplement or Medicare select policy/certificate to enroll in this Medicare plan? If "YES,"</p> <p>(g) Is your former Medicare Supplement plan or Medicare select policy/certificate still available?</p>	<div style="margin-bottom: 10px;"> Start ____/____/____ End ____/____/____ </div> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No _____ ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="margin-bottom: 10px;"> Start ____/____/____ End ____/____/____ </div> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No _____ ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

Application For: Medicare Supplement Coverage

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

4. Do you have another Medicare Supplement or Medicare Select insurance policy or certificate in force? (a) If "YES," with what company, and what plan do you have?	Applicant A <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant B <input type="checkbox"/> Yes <input type="checkbox"/> No	
Applicant A	Applicant B		
Name of Company	Name of Company		
Plan	Plan		
Effective Date ___/___/_____	Effective Date ___/___/_____		
(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy..... (c) If "YES," indicate termination date..... (d) If "YES," have you received a copy of the replacement notice?	Applicant A <input type="checkbox"/> Yes <input type="checkbox"/> No ___/___/_____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant B <input type="checkbox"/> Yes <input type="checkbox"/> No ___/___/_____ <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare Supplement plan) (a) If "YES," with what company and what kind of policy/certificate? (List below.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Applicant A	Applicant B		
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate
(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank. (c) Reason for termination/disenrollment? _____/_____ <div style="display: flex; justify-content: space-around;"> Applicant A Applicant B </div> (d) Planned date of termination/disenrollment? ___/___/_____	Applicant A Start ___/___/_____ End ___/___/_____ ___/___/_____	Applicant B Start ___/___/_____ End ___/___/_____ ___/___/_____	
6. Producers shall list any other health insurance policies/certificates they have sold to the applicant. (a) List policies/certificates sold which are still in force.	Applicant 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 are no longer in force.			
Applicant A	Applicant B		

Application For: Medicare Supplement Coverage

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 any of 16 B, C, D, or E that person is not eligible for Medicare Supplement Coverage.

	Applicant A	Applicant B
1. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been advised by a physician that surgery may be required within the next 12 months for cataract(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been hospitalized two or more times within the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you currently hospitalized, bedridden, living in a nursing facility, receiving hospice or home health care, using a wheelchair or a motorized mobility aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had an organ transplant or amputation caused by disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been diagnosed with emphysema or chronic pulmonary disorder other than asthma, or have you been treated with supplemental oxygen or a nebulizer for a pulmonary disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been diagnosed with Parkinson's disease, multiple sclerosis, ALS (amyotrophic lateral sclerosis), systemic lupus, or myasthenia gravis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you been diagnosed with, Alzheimer's disease, senile dementia or any other cognitive disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC,) or tested positive for the presence of HIV antibodies, antigens or the virus with tests consisting of both a positive screening test such as enzyme-linked immunoassay (ELISA) and a positive supplemental test such as a Western Blot?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past two years, have you been treated or been advised by a physician to have treatment for internal cancer or melanoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Within the past two years, have you been treated or been advised by a physician to have treatment for chronic kidney disease, cirrhosis, or chronic hepatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Within the past two years, have you been treated or been advised by a physician to have treatment for alcoholism, drug abuse, mental or nervous disorder requiring psychiatric hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Within the past two years, have you been treated or been advised by a physician to have treatment for heart attack, coronary artery disease, congestive heart failure, enlarged heart , heart valve surgery, or heart rhythm disorders including use of pacemaker or defibrillator?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Within the past two years, have you been treated or been advised by a physician to have treatment for stroke, transient ischemic attack (TIA), carotid artery disease, or peripheral vascular disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Within the past two years, have you been treated or been advised by a physician to have treatment for osteoporosis with a fracture or fractures, rheumatoid arthritis, or crippling or disabling arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. A. Have you been diagnosed with diabetes? If yes, have you also been:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. advised by a medical professional to take more than 50 units of insulin daily or three or more medications (insulin and oral)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. diagnosed with retinopathy or neuropathy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. diagnosed with heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. treated for high blood pressure with three or more medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No (please attach a separate sheet if needed)		Applicant B <input type="checkbox"/> Yes <input type="checkbox"/> 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	

Application For: Medicare Supplement Coverage

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 monthly withdrawal to come from my (check one below) on the _____ day (must be between the 1st and 28th) of the month:

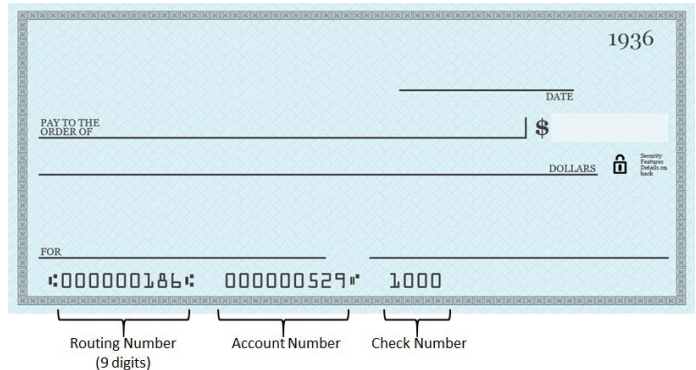
Checking

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.

- Payments cannot be postponed from the date selected.
- Payment from a third party, including any foundation, will not be accepted.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.



Financial Institution Name:

Phone #:

Financial Institution Address:

Transit Routing # (from left side of check)

Account # (from right side of check)

X _____
 Authorized Signature as Shown on Account

_____/_____/_____
 Date

X _____
 Authorized Signature as Shown on Account

_____/_____/_____
 Date

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

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
- 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

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date

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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

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date



Liberty Bankers Life

Insurance Company

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:

Medicare Supplement

- Plan A
- Plan F
- Plan G
- Plan N

Applicant B:

Medicare Supplement

- Plan A
- Plan F
- Plan G
- 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

Signature of Producer

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

Name of Agency

Signature of Applicant

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



Liberty Bankers Life

Insurance Company

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

Use this fax number only for applications and new business documents. Applications faxed to any other number can cause delays in processing your business.

Please complete the following information:

Total number of pages being faxed including this cover sheet _____

Producer Name: _____

Producer Number or NPN: _____

Producer Phone Number: _____

Producer Fax Number: _____

Comments: _____

This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Liberty Bankers Life Insurance Company and its affiliates. It may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, at 1-844-770-2400. We will arrange for you to return the original material to us via the US Postal Service and if requested, we will reimburse you for such expense.