Liberty Bankers Life
Insurance Company

Application for Medicare Supplement Insurance

Florida

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 #

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.

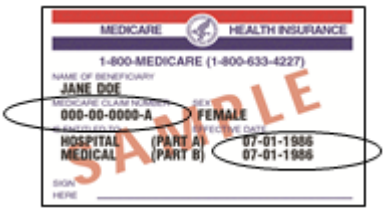
SECTION 1. PLAN & PREMIUM PAYMENT INFORMATION - TO BE COMPLETED BY AGENT/PRODUCER

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

Applicant A	**Applicant B**
Medicare Supplement Plan Applied for: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N	Medicare Supplement Plan Applied for: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N
Requested Effective Date _____/_____/_____ mo / day / yr	Requested Effective Date _____/_____/_____ mo / day / yr
Mail Policy To: ☐ Insured ☐ Agent	Mail Policy To: ☐ Insured ☐ Agent
Calculated Premium (include app fee; HHD) $ _____ - $ _____ + $ _____= $ _____ premium HHD app fee total	Calculated Premium (include app fee; HHD) $ _____ - $ _____ + $ _____= $ _____ premium HHD app fee total
Select Premium Payment Option: ☐ ACH Annual ☐ Annual direct ☐ ACH Semi-annual ☐ Semi-annual direct ☐ ACH Quarterly ☐ Quarterly direct ☐ ACH Monthly (direct monthly is not available)	Select Premium Payment Option: ☐ ACH Annual ☐ Annual direct ☐ ACH Semi-annual ☐ Semi-annual direct ☐ ACH Quarterly ☐ Quarterly direct ☐ 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 _____+_____	State ZIP _____+_____
Mailing Address (if different from physical address)	Mailing Address (if different from physical address)
City	City
State ZIP _____+_____	State ZIP _____+_____

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
☐ Male ☐ Female State of Birth _____	☐ Male ☐ Female State of Birth _____
In the past 12 months, have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes? ☐ Yes ☐ No	In the past 12 months, have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes? ☐ Yes ☐ 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?** ☐ Yes ☐ 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?** ☐ Yes ☐ No**...**
Please reference your Medicare Card to complete the following questions.	
Medicare Health Insurance Card Claim Number (if known)	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 Please complete the following: Medicare Part A Effective Date: _____/_____/_____ Medicare Part B Effective Date: _____/_____/_____ 3. If you are applying to have coverage effective under age 65, do you have a disability or End Stage Renal Disease? ☐ Yes ☐ No	**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 Please complete the following: Medicare Part A Effective Date: _____/_____/_____ Medicare Part B Effective Date: _____/_____/_____ 3. If you are applying to have coverage effective under age 65, do you have a disability or End Stage Renal Disease? ☐ 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. 1. Do you currently live with your legal spouse, including validly recognized civil union and domestic partners, who owns or is issued a Medicare Supplement policy with us, 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 and at least one owns or is issued a Medicare Supplement policy with us? 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)	Liberty Bankers Life Insurance Policy Number	
Street Address		
City/State/Zip		
Name (First/Middle/Last)	Liberty Bankers Life Insurance Policy Number	
Street Address		
City/State/Zip		
Name (First/Middle/Last)	Liberty Bankers Life Insurance Policy Number	
Street Address		
City/State/Zip		

SECTION 4. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that 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.

To the Best of Your Knowledge:	**Applicant A**	**Applicant B**
1. Are you applying during a guaranteed issue period? ..... **(NOTE: If the answer above is "YES," please attach proof of eligibility.)**	☐ Yes ☐ No	☐ Yes ☐ No
2. 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?	☐ Yes ☐ No	☐ Yes ☐ 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?.....	**Applicant A** ☐ Yes ☐ No	**Applicant B** ☐ Yes ☐ No

SECTION 4. FOR YOUR PROTECTION, Continued, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

	Applicant A	Applicant B
(c) If "YES," indicate termination date.....	_____/____/_____	____/____/_____
(d) If "YES," have you received a copy of the replacement notice?	☐ Yes ☐ No	☐ Yes ☐ No
(e) NOT INCLUDING Medicare Supplement, have you had before or do you now have any other Medicare plan coverage as referenced below? …..... If you answer "NO" skip to question #4 below. If you answer "YES," please complete questions 3 (a-g) below.	☐ 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?	_____ Applicant A	_____ Applicant B
(d) Planned date of termination/disenrollment?	____/____/_____ Applicant A	____/____/_____ Applicant B

	Applicant A	Applicant B
(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
4. 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.)	☐ Yes ☐ No	☐ Yes ☐ No

Applicant A		Applicant B	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

	Applicant A	Applicant B
4. (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?	Start ____/____/_____ End ____/____/_____	Start ____/____/_____ End ____/____/_____
_____/_____ **Applicant A** **Applicant B** (d) Planned date of termination/disenrollment?	____/____/_____	____/____/_____

SECTION 4. FOR YOUR PROTECTION, Continued, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.		
5. 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",	☐ 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
6. Agents/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 A	**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**

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.

Height: ___ feet ___ inches Weight:_____ pounds	Height: ___ feet ___ inches Weight:_____ pounds

		Applicant A	**Applicant B**
1.	Have you been advised by a licensed member of the medical profession to have surgery, medical tests, treatment or therapy that has not been performed?	☐ Yes ☐ No	☐ Yes ☐ No
2.	Have you been advised by a licensed member of the medical profession that surgery may be required within the next 12 months for cataract(s)?	☐ Yes ☐ No	☐ Yes ☐ No
3.	Have you been hospitalized two or more times within the last two years?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
5.	Have you had an organ transplant or amputation caused by disease?	☐ Yes ☐ No	☐ Yes ☐ No
6.	Have you been diagnosed by a licensed medical professional with emphysema or chronic pulmonary disorder other than asthma, or have you been treated with supplemental oxygen or a nebulizer for a pulmonary disorder?	☐ Yes ☐ No	☐ Yes ☐ No
7.	Have you been diagnosed by a licensed medical professional with Parkinson's disease, multiple sclerosis, ALS (amyotrophic lateral sclerosis), systemic lupus, or myasthenia gravis?	☐ Yes ☐ No	☐ Yes ☐ No
8.	Have you been diagnosed by a licensed medical professional with, Alzheimer's disease, senile dementia or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
9.	Have you tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 5. HEALTH QUESTIONS, Continued - 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.		
10. Within the past two years, have you been treated or advised by a licensed member of the medical profession to have treatment for internal cancer or melanoma?	☐ Yes ☐ No	☐ Yes ☐ No
11. Within the past two years, have you been treated or advised by a licensed member of the medical profession to have treatment for chronic kidney disease, cirrhosis, or chronic hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No
12. Within the past two years, have you been treated or advised by a licensed member of the medical profession to have treatment for alcoholism, drug abuse, mental or nervous disorder requiring psychiatric hospitalization?	☐ Yes ☐ No	☐ Yes ☐ No
13. Within the past two years, have you been treated or advised by a licensed member of the medical profession 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?	☐ Yes ☐ No	☐ Yes ☐ No
14. Within the past two years, have you been treated or advised by a licensed member of the medical profession to have treatment for stroke, transient ischemic attack (TIA), carotid artery disease, or peripheral vascular disease?	☐ Yes ☐ No	☐ Yes ☐ No
15. Within the past two years, have you been treated or advised by a licensed member of the medical profession to have treatment for osteoporosis with a fracture or fractures, rheumatoid arthritis, or crippling or disabling arthritis?	☐ Yes ☐ No	☐ Yes ☐ No
16. A. Have you been diagnosed by a licensed medical professional with diabetes? If yes, have you also been: B. advised by a licensed member of the medical profession to take more than 50 units of insulin daily or three or more medications (insulin and oral)? C. diagnosed by a licensed medical professional with retinopathy or neuropathy? D. diagnosed by a licensed medical professional with heart disease? E. treated for high blood pressure with three or more medications?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ 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 ☐ Yes ☐ No (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	

SECTION 6. MEDICATION INFORMATION

	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.

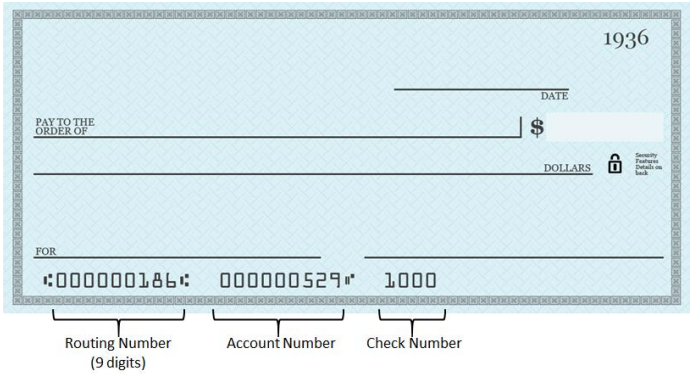
I would like my automatic monthly withdrawal to come from my (check one below) on the _____ day (must be between the 1st and 28th) of the month:

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.

SECTION 7. METHOD OF PAYMENT, Continued – PLEASE COMPLETE ALL QUESTIONS

- 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

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

SECTION 8. AUTHORIZATION AND ACKNOWLEDGEMENT

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. 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 person who knowingly and with intent to injure , defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

To the best of my knowledge and belief, I wish to apply for a Medicare Supplement insurance policy. I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. I represent that my answers and statements on this application are true and complete. Statements made in this application are representations and not warranties. 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**

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.

X_____ _____
(Signature of Licensed Agent/Producer) Agent/Producer Printed Name

_____ _____
FLORIDA LICENSE IDENTIFICATION NUMBER Date

SECTION 9. FOR ADDITIONAL COMMENTS

Applicant A (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

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):

Applicant A	**Applicant B**
☐ Additional benefits	☐ Additional benefits
☐ No change in benefits, but lower premiums	☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums	☐ Fewer benefits and lower premiums
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D	☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)	☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
☐ Other (please specify) _____	☐ Other (please specify) _____

1. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
2. 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/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 A's Signature

Applicant B's Signature

Date

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):

Applicant A	**Applicant B**
☐ Additional benefits	☐ Additional benefits
☐ No change in benefits, but lower premiums	☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums	☐ Fewer benefits and lower premiums
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D	☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)	☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
☐ Other (please specify) _____	☐ Other (please specify) _____

1. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
2. 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/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 A's Signature

Applicant B's Signature

Date

Date

Liberty Bankers Life
Insurance Company

Home Office: 1605 LBJ Freeway, Suite 710, Dallas, Texas, 75234
Administrative Office: PO Box 15357, Clearwater, FL 33766-5357

AGENT CERTIFICATION

I, The Undersigned Insurance Agent Certify:

That, I have taken an application for Policy Form No. _____ offered by Liberty Bankers Life Insurance Company, to _____.

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 am a licensed agent of this insurance company and have given a company receipt for an initial premium in the Amount of $ _____ which has been paid to me by ☐ check ☐ ACH.

That, I have clearly explained that the 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 Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

Signature of Agent _____ Date _____

Name of Agency _____ Phone No. _____

Address of Agent or Agency _____

I, The Undersigned Applicant, Have Received a Copy of This Form:

Signature of Applicant A _____ Date _____

Signature of Applicant B _____ Date _____

Liberty Bankers Life
Insurance Company

Home Office: 1605 LBJ Freeway, Suite 710, Dallas, Texas, 75234
Administrative Office: PO Box 15357, Clearwater, FL 33766-5357

AGENT CERTIFICATION

I, The Undersigned Insurance Agent Certify:

That, I have taken an application for Policy Form No. _____ offered by Liberty Bankers Life Insurance Company, to _____.

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 am a licensed agent of this insurance company and have given a company receipt for an initial premium in the Amount of $ _____ which has been paid to me by ☐ check ☐ ACH.

That, I have clearly explained that the 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 Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

Signature of Agent _____ Date _____

Name of Agency _____ Phone No. _____

Address of Agent or Agency _____

I, The Undersigned Applicant, Have Received a Copy of This Form:

Signature of Applicant A _____ Date _____

Signature of Applicant B _____ Date _____

RETURN TO THE COMPANY

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.

AGENT DISCLOSURE FORM

Liberty Bankers Life Insurance Company
Medicare Supplement Administrative Office: PO Box 15357, Clearwater, FL 33766-9802

I, the undersigned insurance agent, represent Liberty Bankers Life Insurance Company with regard to the sale of its product(s). I am providing you services on behalf of such insurance company.

I have taken an application for:

_____,
(Applicant(s)),

I certify:

☐ **THAT,** I hold a Florida Resident agent License

Or

☐ **THAT,** I hold a Florida Non-Resident agent License and

☐ I took this sale over the phone, or

☐ I took this application in person in the county of _____ , Florida.

_____ _____
Applicant A Name Applicant B Name

_____ _____
Applicant A's Signature Applicant B's Signature

_____ _____
Date Date

_____
Print Name of Agent

_____
Agent's Signature

_____
Date

RETURN TO COMPANY

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: _____