Liberty Bankers Life
Insurance Company

Application for Medicare Supplement Insurance

Maryland

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.

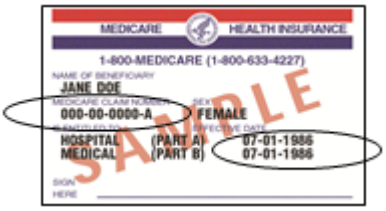
SECTION 1. PLAN & PREMIUM PAYMENT INFORMATION - TO BE COMPLETED BY PRODUCER

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 _____
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: _____/_____/_____	**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: _____/_____/_____

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, 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 ____/____/_____	
	Applicant A	**Applicant B**
(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(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

Application For: Medicare Supplement Coverage

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, CONTINUED

	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?	☐ Yes ☐ No	☐ Yes ☐ No
(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.)		

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

	Applicant A	Applicant B
(b) What are your dates of coverage under the other policy/ certificate? If you are still covered under this plan, leave "END" blank.	Start ____/____/_____ End ____/____/_____	Start ____/____/_____ End ____/____/_____
(c) Reason for termination/disenrollment? _____/_____ **Applicant A** **Applicant B**		
(d) Planned date of termination/disenrollment?	____/____/_____	____/____/_____
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. 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

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
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? ☐ 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

	Applicant A	Applicant B
1. Within the past seven years have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you been advised by a physician 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. Within the past seven years have you had an organ transplant or amputation caused by disease?	☐ Yes ☐ No	☐ Yes ☐ No
6. Within the past seven years have you been diagnosed with or treated for 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. Within the past seven years have you been diagnosed with or treated for Parkinson's disease, multiple sclerosis, ALS (amyotrophic lateral sclerosis), systemic lupus, or myasthenia gravis?	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past seven years have you been diagnosed with or treated for Alzheimer's disease, senile dementia or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
9. Within the past seven years have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC,) or Human Immunodeficiency Virus (HIV) infection?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
16. A. Within the past seven years have you been diagnosed with or treated for diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, within the past seven years have you also been:		
B. advised by a medical professional to take more than 50 units of insulin daily or three or more medications (insulin and oral)?	☐ Yes ☐ No	☐ Yes ☐ No
C. diagnosed with or treated for retinopathy or neuropathy?	☐ Yes ☐ No	☐ Yes ☐ No
D. diagnosed with or treated for heart disease?	☐ Yes ☐ No	☐ Yes ☐ No
E. treated for high blood pressure with three or more medications?	☐ 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 Prescribed	____/____/______
	Frequency and Dosage	
	Diagnosis/Condition/Reason	
	Medication Name (as shown on label)	
____/____/______	Date Prescribed	____/____/______
	Frequency and Dosage	
	Diagnosis/Condition/Reason	
	Medication Name (as shown on label)	
____/____/______	Date Prescribed	____/____/______
	Frequency and Dosage	
	Diagnosis/Condition/Reason	
	Medication Name (as shown on label)	
____/____/______	Date Prescribed	____/____/______
	Frequency and Dosage	
	Diagnosis/Condition/Reason	
	Medication Name (as shown on label)	
____/____/______	Date 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.

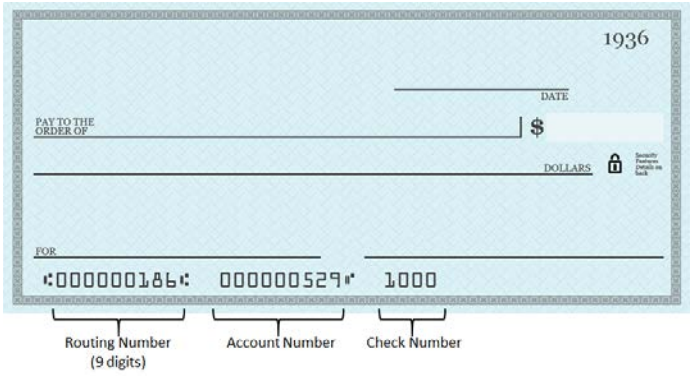
I authorize Liberty Bankers Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes I authorize you, my financial institution, to pay from my account to "Liberty 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	X_____ Authorized Signature as Shown on Account
_____/_____/_____ Date	_____/_____/_____ Date

Application For: Medicare Supplement Coverage

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, for a period not to exceed 24 months in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. 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. 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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Medicare Supplement insurance policy. To the best of my knowledge and belief, 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**

Application For: Medicare Supplement Coverage

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

X_____ _____
(Signature of Licensed Producer) 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):

- ❒ 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

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

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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

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

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

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- ❒ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.

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- ❒ 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.

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_____ _____

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

RETURN TO COMPANY

Liberty Bankers Life
Insurance Company

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

Eligible Persons for Guarantee Issue and Open Enrollment

An individual is eligible for guarantee issue if any of the following situations are applicable:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or the plan ceases to provide all supplemental health benefits to the individual;

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply:

- (a) The certification of the organization or plan under the federal Social Security Act has been terminated;
- (b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
- (c) The individual is no longer eligible to elect the plan because:
  - (i) Of a change in the individual's place of residence,
  - (ii) Of another change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in the federal Social Security Act (when the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under the federal Social Security Act), or
  - (iii) The plan is terminated for all individuals within a residence area;
- (d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
  - (i) The organization offering the plan substantially violated a material provision of the organization's contract under Part C of Medicare in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide medically necessary covered care in accordance with applicable quality standards, or
  - (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
- (e) The individual meets any other exceptional conditions as the Secretary may provide;

(3) The individual is 65 years old or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under the Social Security Act, and there are circumstances similar to those described in (2) that would permit discontinuance of the individual's enrollment with the PACE provider if the individual were enrolled in a Medicare Advantage plan;

(4) The individual:

- (a) Is enrolled with:
  - (i) An eligible organization under a contract under the federal Social Security Act (Medicare cost),
  - (ii) A similar organization to the organization described in (4)(a)(i) operating under demonstration project authority, effective for periods before April 1, 1999,
  - (iii) An organization under an agreement under the federal Social Security Act (health care prepayment plan), or
  - (iv) An organization under a Medicare Select contract; and

(b) Ceases to be enrolled under the same circumstances that would permit discontinuance of an individual's election of coverage under (2);

(5) The individual is enrolled under a Medicare supplement contract and the enrollment ceases because of:

(a) The insolvency of the issuer or bankruptcy of the nonissuer organization or other involuntary termination of coverage or enrollment under the contract;

(b) The issuer of the contract substantially violated a material provision of the contract; or

(c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the contract's provisions in marketing the contract to the individual;

(6) The individual:

(a) Was enrolled under a Medicare supplement contract and terminates enrollment and subsequently enrolls, for the first time with:

(i) Any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare,

(ii) Any eligible organization under a contract under the federal Social Security Act (Medicare cost),

(iii) Any similar organization operating under demonstration project authority,

(iv) A Medicare Select contract, or

(v) Any Program of All-Inclusive Care for the Elderly (PACE) provider under the Social Security Act; and

(b) Terminates the subsequent enrollment under (6)(a) during any period within the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under the federal Social Security Act);

(7) The individual, upon first becoming enrolled in Part B of Medicare at 65 years old or older, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under the Social Security Act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment; or

(8) The individual:

(a) Enrolls in a Medicare Part D plan during the initial enrollment period;

(b) At the time of enrollment in Part D:

(i) Was enrolled under a Medicare supplement contract that covers outpatient prescription drugs; and

(ii) Terminates enrollment in the Medicare supplement contract described in (8)(b)(i); and

(c) Submits evidence of enrollment in Medicare Part D with the application for a contract.

(9) Individuals who are applying within 63 days after their employee welfare benefit plan terminated and who are not eligible for credit for health insurance costs under § 35 of the Internal Revenue Code and enrollment in the Maryland Health Insurance Plan solely due to eligibility for Medicare.

An individual is eligible for open enrollment if any of the following situations are applicable:

(1) The individual

(a) is at least 64 ½ years of age and within six months before or after his/her effective date for Medicare Part B, or

(b) is covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

(c) Is under the age of 65 years but is eligible for Medicare due to a disability, and an application for a Medicare supplement contract or certificate plans A or C is submitted:

(i) during the 6-month period following the applicant's enrollment in Part B of Medicare; or

(ii) during the 6-month period after the individual's termination from the Maryland Health Insurance Plan as a result of enrollment in Part B of Medicare.

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: _____