Liberty Bankers Life
Insurance Company

Application for Medicare Supplement Insurance

Virginia

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 10 if additional space is needed.

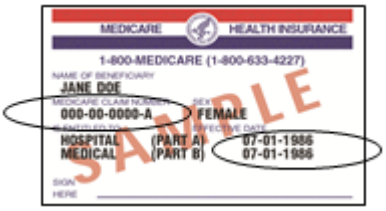
SECTION 1. PLAN & PREMIUM PAYMENT INFORMATION - TO BE COMPLETED BY AGENT

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 Start Date _____/_____/_____ mo / day / yr	Requested Start 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)

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, 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 as proof of your eligibility.**
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. Did you turn age 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES", please complete the following:		
Medicare Part A Start Date	____/____/_____	____/____/_____
Medicare Part B Start Date	____/____/_____	____/____/_____
3. Are you applying during a guaranteed issue period? ..... **(NOTE: If the answer above is "YES," please attach proof of eligibility.)**	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you have another Medicare Supplement or Medicare Select insurance policy or certificate in force?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," with what company, and what plan do you have?		

Applicant A	**Applicant B**
Name of Company	Name of Company
Plan	Plan
Start Date ____/____/_____	Start Date ____/____/_____

	Applicant A	**Applicant B**
(b) If question 4(a) is answered "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
5. 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

	Applicant A	Applicant B
(c) Reason for termination/disenrollment?	_____	_____
(d) Planned date of termination/disenrollment?	____/____/_____	____/____/_____
	Applicant A	Applicant B

Application For: Medicare Supplement Coverage

SECTION 4. FOR YOUR PROTECTION, 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
6. 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. (c) Reason for termination/disenrollment? _____/_____ **Applicant A** **Applicant B**	Start ____/____/_____ End ____/____/_____	Start ____/____/_____ End ____/____/_____
(d) Planned date of termination/disenrollment?	____/____/_____	____/____/_____
7. 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

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 - For applicants who are applying as an Open Enrollee or meet guarantee issue requirements, these questions should not be answered.

For all other applicants, 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, additional medical information may be required to determine eligibility for this coverage. Complete this section by checking "Yes" or "No" for each question.

Applicant A	**Applicant B**
Height: ___ Ft _____ In Weight: _____ Lbs	Height: ___ Ft _____ In Weight: _____ Lbs

	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?	☐ 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. Have you had an organ transplant or amputation caused by disease?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you been diagnosed with Parkinson's disease, multiple sclerosis, ALS (amyotrophic lateral sclerosis), systemic lupus, or myasthenia gravis?	☐ Yes ☐ No	☐ Yes ☐ No
8. Have you been diagnosed with, Alzheimer's disease, senile dementia or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you been diagnosed with 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. Have you been diagnosed with diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, 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 retinopathy or neuropathy?	☐ Yes ☐ No	☐ Yes ☐ No
D. diagnosed with heart disease?	☐ Yes ☐ No	☐ Yes ☐ No
E. treated for high blood pressure with three or more medications?	☐ Yes ☐ No	☐ Yes ☐ No

Application For: Medicare Supplement Coverage

17. 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	☐ 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 10 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	
	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 start date of coverage or on the date specified on this application.

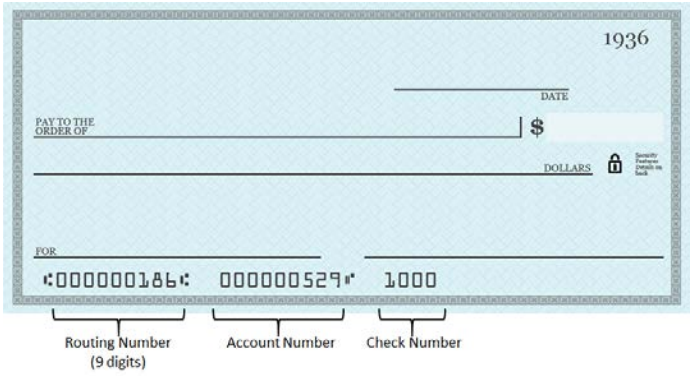
I authorize Liberty Bankers Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes I authorize you, my financial institution, to pay from my account to "Liberty 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.
- 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, 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 personal information concerning medical 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 Liberty Bankers Life Insurance Company or its reinsurers for purposes of underwriting. 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:

- personal information, including protected health 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
- I, or my authorized representative, 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, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

I wish to apply for a Medicare Supplement insurance policy. The undersigned applicant(s) and agent certify that the applicant(s) has read, or had read to them, the completed application and that the applicant(s) realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. The applicant(s) and agent understand the Company will conduct a telephone interview with the applicant(s) regarding the answers. The applicant(s) and agent understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the policy.

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 9. TO BE COMPLETED BY AGENT	
Agents 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
Start Date of Coverage / /	Start Date of Coverage / /
(b) List policies/certificates sold in the past five (5) years which are no longer in force.	
Applicant A	**Applicant B**

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.

_____
AGENT NUMBER

X_____ _____
(Signature of Licensed Agent) Date

SECTION 10. 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

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- ❒ 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) _____

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Signature of Agent, Broker or Other Representative | Agent's Printed Name and Address

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_____ _____

Applicant's Signature | Date

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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

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

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

Offered by **Liberty Bankers Life Insurance Company**,

to _____
(Applicant(s)),

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

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

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

_____
Date

_____
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

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

ADMINISTRATIVE INFORMATION

Applicant	**Applicant B**
Name:	Name:
Were you eligible for Medicare on or prior to 12/31/2019? ☐ YES ☐ NO Please complete the following: Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____	Were you eligible for Medicare on or prior to 12/31/2019? ☐ YES ☐ NO Please complete the following: Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____

_____
Signature of Applicant
Date _____

_____
Signature of Applicant B
Date _____

Agent Name_____

Agent Signature _____ Date_____

RETURN TO 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.

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: _____