Liberty Bankers™
Insurance Group | For Life

The Liberty Bankers Insurance Group
1605 Lyndon B. Johnson Freeway, Suite 700
Dallas, TX 75234

Final Expense Paperless Application Process Instructions

The Liberty Bankers Life Insurance Group **(LBIG)** paperless application process provides our Agents with a unique Final Expense sales experience. No longer required are the hassles of filling out and submitting applications, HIPPA, most disclosure forms, bank draft forms, etc. **It's EZ as 1 — 2 — 3.**

1. **The Agent** makes the final expense sale with client either Face to Face or Telephonically.
2. **The Agent**, with the client, calls our LBIG Telephonic Processing Center **(TPC)** for the instant underwriting decision and application completion. Three-way calls are acceptable.
3. **TPC** gathers basic information from the Agent and Applicant to make an instant underwriting decision. If acceptable, then proceeds to complete the application process

Instructions and Tips for the Paperless App Process

1. **Once the Agent** makes the final expense sale with the client:
   a. **Pre-qualify the applicant** using the health question section of the Paperless App Pac, Field Rx Guide, and the Build Chart. These tools can be found in your Agent Portal under **"Quick Links"**.
   b. Using the worksheet, record the applicant's personal and banking information.
   c. Make sure you read and made the prospect aware of all the required disclosures, including HIPAA, MIB, Fair Credit Report, and ALB rider benefit, **including the correct state replacement form** if replacing business. TPC will verify with both the agent and applicant.
2. **Once worksheet is completed and disclosures read, the Agent** will make the call to **TPC** to initiate the Point of Sale Telephone Interview **(POSTI)** for instant underwriting decision **AND** application paperwork completion! Information from the worksheet will be required during this interview from the agent. **Complete and accurate data will make the call timely. TPC** will begin the process with an interviewer as follows:
   a. Ask both agent and applicant's basic personal information. The interviewer will verify with the applicant their personal information, height and weight, health questions, and all authorizations, in order to give an instant underwriting decision.
   b. If applicant is approved, the interviewer will speak with both the agent and applicant to complete the application for policy issue. This includes plan, riders, premium, banking information, beneficiaries, and doctor information. Finally obtain applicant (and owner and/or payor if different) voice signatures for authorizations.
3. **Once the Call is over,** the Agent retains the worksheet for their record. NO need to send in anything and the client's policy will be issued and mailed.

EXCEPT FOR THE FOLLOWING: Agent must note POSTI reference # on the upper right corner for any required form before faxing (888-525-5002) or emailing (agentnbinfo@life-insurers.com) to new business. Info on top of worksheet.

California: Medical Eligibility Disclosure (#7404.4-0505) Home Meeting Disclosure for 65 & Over (7404.2-0505) Financial Product Disclosure 65 & Over (7404.3-0505)

The LBIG Telephonic Processing Center Hours of Operation
Monday thru Friday 9 am — 10 pm Saturday 9 am — 4 pm Eastern Standard Time
844-442-9871

Not all products are available in all states. For information about your state, please contact 800-731-4300.
For Agent use only.This piece is not intended to create public interest in an insurance company, insurance product, or an insurance professional.

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SECTION I: Interviewer will speak to the agent for Underwriting Decision

Agent Information:

Agent Number:			
Agent First and Last Name:			
City and State will the Applicant be signing this application:			
Will the proposed Insured be the PAYOR and/or OWNER of this policy? **Yes** **No**			
Payor Name:		Owner Name:	
If other than insured, will the payor AND/OR owner be available to voice authorize for the application during this phone call? **Yes** **No**			
Payer/Owner relationship to the applicant:			

Proposed Insured Information:

Gender:		SSN OR TIN:		DOB:	
Country of Birth:		State of Birth:			
City and State will the Applicant be signing this application:					
Email Addres (Suggested but Optional):					
Street Address:					
City:		State:		Zip:	

SECTION II: Interviewer will speak to the Proposed Insured for Underwriting Decision

A.	At this time the Interviewer will ask and verify the personal information, Height and Weight, all authorizations, including required read authorizations for HIPPA and replacement.
B.	Once Authorizations are verified, the interviewer will ask all of the health questions from the Health History section, Part I, II, and III questions, along with Rx Check and MIB, are required for determining the eligibility of the insured.
C.	Now the dicision will be made and the interviewer will ask the client to give the phone back to the agent.

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SECTION III: Interviewer will speak to the Agent for decision and application completion

Agent will be given the u/w decision and asked if call should continue to finish the application with all required voice signatures.					
Face Amount of the policy:	$			Are there any riders? **Yes** **No**	
A D & D:		Children's Term Rider?		# Units?	
Granchild Rider?		Number of Grandchildren on the rider?			
Premium Mode	Monthly Bank Draft	Quarterly	Semi-Ann	Annually	
Bank Draft mode requires banking information from Payment Method Worksheet page 7					
Interviewer will verify the premium with the Agent and continue to finish the application.					
Should bank draft match Social Security Billing? **Yes** **No**			Checking	Savings	
Draft Date?		Draft First Premium? **Yes** **No**	When?		
If Insured is not the premium payor, please complete this section. Must be available.					
PAYOR/OWNER First, MI, Last name:					
SSN:		DOB:		Telephone Number:	
Email Address (Optional):					
Where will the policy be mailed to: **Policyholder** or **Agent**					
If replacing business, please complete proper state form and have available.					
Does the proposed insured have any existing life or annuity contracts? **Yes** **No**					
Will this insurance replace or change any other insurance or annuity contracts? **Yes** **No**					
Primary and Continget Beneficiary Section: Optional to Provide Address, Phone, Email					

PRIMARY BENEFICIARY		CONTINGENT BENEFICIARY	
Name:		Name:	
Relationship:		Relationship:	
Percentage:		Percentage:	
Name:		Name:	
Relationship:		Relationship:	
Percentage:		Percentage:	

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SECTION III Continued:

At this time the interviewer will speak with the insured to complete the process. This includes authorizations, verifications or disclosures given, fraud warnings, and voice signatures.					
Personal Physicial Information:					
Name:		City/State:			
Telephone:					
IF APPLICABLE: At this time the interviewer will speak with the PAYOR and/or OWNER to complete the process. This includes authorizations and voice signatures.					
At this time the interviewer will speak with the AGENT to complete the process. This includes authorizations, verifications of disclosures given, fraud warnings, and voice signatures. Including the following information:					
Are you related to the Insured? **Yes** **No**		Application Taken: **Personally** or **Telesales**			
Agent Split? **Yes** **No**	Other Agent:	Name:		#:	
CASE NUMBER:					

PRIMARY APPLICATION FOR INSURANCE: HEALTH HISTORY

Part 1 – All Health Questions Must be Answered by Proposed Insured.

Have you, the Proposed Insured, ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:	YES	NO
1. Congestive heart failure (CHF), cardiomyopathy, memory loss, Alzheimer's, senile dementia, dementia, heart defibrillator implant, two or more instances of internal cancer(s), or terminal illness ("terminal illness" means a disease or illness that is expected to result in death within 24 months)?	□	□
2. Organ transplant (other than corneal), untreated Hepatitis C, kidney failure or dialysis, amputation due to diabetic complications, multiple sclerosis, muscular dystrophy, mental retardation, amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease, Downs's syndrome, cystic fibrosis, or Huntington's disease?	□	□
3. Diabetes at age 9 or younger?	□	□
4. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, tested positive for human immunodeficiency viruses (HIV), or any other disorder of the immune system?	□	□
5. Within last 2 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for uncontrolled diabetes or uncontrolled high blood pressure?	□	□
6. Within the last year have you been confined to a hospital, been advised by a member of the medical profession to have surgery or hospitalization, used oxygen due to a medical condition, been unable to care for yourself or been bedridden at home or in a nursing home, hospice, long-term care, or assisted living facility? Definition of assisted living: requires help in at least one area of skills considered necessary for living and caring for oneself (feeding, dressing or bathing)?	□	□

If all "No" answers in Part 1, Proposed Insured should complete Part 2.

Part 2 Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.

7. Within the past 2 years have you, the Proposed Insured, been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:	YES	NO
(a) Angina (chest pain), any type of heart or circulatory surgery, heart attack, or received a pacemaker or stent?	□	□
(b) Stroke, Transient Ischemic Attack (TIA/mini-stroke) or paralysis?	□	□
(c) Cancer or received or been advised to receive chemotherapy or radiation for cancer (the term "cancer" includes melanoma, but excludes basal cell skin cancer)?	□	□
(d) Aneurysm, brain tumor, or sickle cell anemia?	□	□
(e) Complications of diabetes such as nephropathy (kidney), neuropathy (nerve, circulatory), retinopathy (eye) diabetic coma, or insulin shock?	□	□
(f) Alcohol or drug abuse, illegal use of drugs?	□	□
(g) Use of a walker, wheelchair, or electric scooter due to chronic illness or disease?	□	□
8. Have you ever plead guilty to or been convicted of a felony or misdemeanor or do you have such charge currently pending against you? **(If so, was it in the prior 2 years?)**	□	□

If all "No" answers in Part 2, complete Part 3. Otherwise, select MWL & check for state availability.

Part 3 Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.

9. Have you, the Proposed Insured, by a member of the medical profession, ever been diagnosed with, or received, or been advised to receive treatment or medication for:	YES	NO
(a) Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, emphysema, peripheral vascular disease or peripheral artery disease?	□	□
(b) Chronic hepatitis, Hepatitis C, cirrhosis of the liver, chronic pancreatitis, liver disease, or kidney disease?	□	□
(c) Insulin use before age 25?	□	□
(d) Irregular heartbeat, atrial fibrillation, Systemic Lupus (SLE), epileptic seizures, or Parkinson's disease?	□	□

If all 'No" answers in Part 3, select SIMPL Preferred. Otherwise, select SIMPL Standard.

Give Details to questions answered "Yes" in Parts 2 and 3, above **(attach additional sheet, if necessary with Proposed Insured's signature).** You may also provide other additional information here.

_____

_____

OPTIONAL RIDER(S): SUPPLEMENTAL APPLICATION

Applying For: ☐ **Accidental Death & Dismemberment $ _____**
☐ **Child Rider # of Units _____ (max 4 units, $5,000 insurance per unit)**
☐ **Grandchild Rider $7,500 each for ____ grandchildren**

Section 1: INFORMATION ABOUT PRIMARY INSURED AND POLICY

Name of Primary Insured Under Policy:	Date of Policy or Primary Application:	Policy Number (if applicable)

Address	City	State	Zip Code

Section 2: INFORMATION ABOUT CHILDREN / GRANDCHILDREN PROPOSED FOR INSURANCE (please print): *Name all of the Primary Insured's natural born, step, and legally adopted children or grandchildren older than 15 days but younger than 18 years of age.*

Full Name of Proposed Insured Child/Grandchild	Date of Birth	Age Last Birthday	Sex	Amount	Relationship to Primary Insured	Height	Weight

Section 3: HEALTH INFORMATION

Has any Proposed Insured Child/Grandchild ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession:

A. For cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, mental retardation, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorders of the muscles or bones, anemia or other disorders of the blood, bladder, kidneys, liver or lungs?..... ☐ Yes ☐ No

B. For an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)?..... ☐ Yes ☐ No

Has any Proposed Insured Child/Grandchild ever received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?..... ☐ Yes ☐ No

Please provide details to any "Yes" answer to question 1-3 (Attach another sheet if necessary):

Proposed Insured Child/Grandchild	Condition & Treatment	Date	Name & Address of Physician or Hospital

Any proceeds payable under the rider for this Application will be paid to the Owner, if living. Otherwise, per the beneficiary provision of the rider as follows:

PREMIUM PAYMENT METHODS: SELECT ONE

Complete this section if proposed insured is paying by electronic bank draft. This information will be taken over the phone during the interview.

Account Name:_____ ☐ Checking ☐ Savings

Transit Number: _____ Account Number:_____

Financial Institution Name & Address:_____

- OR -

Complete this section if proposed insured pays by cash or check.

CONDITIONAL RECEIPT FOR CASH OR CHECK RECEIVED WITH APPLICATION
(DO **NOT** COMPLETE FOR ACH OR BANK DRAFT FOR A FUTURE DATE)

INSURANCE BASED ON THE APPLICATION WILL TAKE EFFECT ONLY IF BOTH OF THESE CONDITIONS ARE MET:

1. On the effective date for coverage the Proposed Insured is insurable under Liberty Bankers's rules for the applied for plan, amount, and premium rate.

2. That the sum paid is equal to the full first premium.

INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ON THE LATEST OF: (a) date of the application; or (b) date requested in the application; or (c) date of the last medical requested by the Company.

The total amount of all Liberty Bankers coverage that may become effective prior to delivery of the policy to the Owner shall not exceed $25,000. This limit includes riders, inforce, and applied for coverage.

LIBERTY BANKERS LIFE INSURANCE COMPANY has received $ _____ for Applicant (name) _____

X_____ _____
Producer's Signature Date

THE PREMIUM CHECK MUST BE MADE PAYABLE TO LIBERTY BANKERS LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

GENERIC DISCLOSURES FOR PROPOSED INSURED

Included are the three required disclosures (Fair Credit, MIB, and HIPAA) that must be read and given to your applicant prior to the point of sale telephone interview (POSTI). For SIMPL Standard and Preferred plans only, an Accelerated Death Benefit disclosure must also be read and given to the applicant prior to the point of sale telephone interview. Your client will be asked to verify that these were read to them. In addition, the states of Alabama, California, and Pennsylvania require state specific disclosures that must be completed, signed, and faxed to New Business prior to issuing a policy. These state required forms may be obtained from the website in the Forms Portal. Agent must note POSTI reference # on the upper right corner for any required form and fax to new business @888-525-5002.

FAIR CREDIT REPORTING ACT PRE-NOTIFICATION FORM. Thank you for considering Liberty Bankers Life Insurance Company ("Liberty Bankers") as your insurance carrier. Your Application will be processed as quickly as possible. Public Law 91-5088 requires that We advise you that an investigative consumer report may be made in connection with this Application which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through personal interviews with friends, neighbors, and associates. You are entitled to be interviewed in connection with an investigative consumer report; and, you have the right to receive a copy of any investigative consumer report by making a written request within a reasonable period of time.

NOTICE TO APPLICANTS FOR INSURANCE. Information regarding your insurability will be treated as confidential. Liberty Bankers, or its reinsurer(s), may, however, make a brief report of my protected health information to the MIB, Inc., 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, Inc. member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request from you, will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB, Inc. and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts, 02184, telephone 1-866-692-6901, web address: www.mib.com. Liberty Bankers, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

HIPAA AUTHORIZATION

I authorize any medical or medically related provider or institution, rehabilitation professionals, vocational evaluators, health plan or health care clearinghouse that has any records or knowledge about me and, if applicable my dependents, including prescription drug database or pharmacy benefit manager, ambulance or other medical transport service, any insurance company, Medicare or Medicaid agencies or the MIB, Inc. ("MIB") to disclose my health, medical information, and non-medical information to Liberty Bankers Insurance Company, or its reinsurers. My authorization includes 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 understand that Liberty Bankers underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information, except MIB 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 Liberty Bankers, or its reinsurers, to make a brief report of my protected health information to the MIB, Inc.

My authorization is valid for the maximum time period permitted by law in the state where the policy is delivered or issued for delivery. If I die during the contestability period of my coverage, and if permitted by law in the state where the policy is delivered or issued for delivery, then this Authorization will be valid for an additional 24 months from the date of my death. I direct my next of kin or the personal representative of my estate to legally enforce this Authorization after my death.

I know that I, or my authorized representative, may request a copy of this authorization. This authorization may be revoked by me or my authorized representative at any time except to the extent Liberty Bankers has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract or the contract itself. If I do not sign this authorization or if I alter or revoke it, except as specified above, Liberty Bankers may not be able to evaluate my claim or eligibility for insurance. I may revoke this authorization by sending written notice to Liberty Bankers at [P.O. Box 224 – Brownwood, TX 76804-0224, 1-888-525-4467, FAX 1-888-525-5002].

ACCELERATED DEATH BENEFIT PAYMENT RIDER DISCLOSURE

NOTICE: Death benefits, premium payments, and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider do not and are not intended to qualify as long-term care insurance. The accelerated benefits offered under this rider are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.

PREMIUMS
There is no premium charge for the accelerated death benefit rider.

EFFECT ON POLICY VALUES
After payment of the accelerated death benefit, the death benefit of the policy will be reduced by the amount of accelerated death benefit. Any premium payments, cash values, and other obligations and benefits under this policy, excluding that for riders, will be reduced proportionately. Upon a request to accelerate benefits under this rider, the owner and any irrevocable beneficiary will be given a statement demonstrating the effect of the acceleration of benefits on the cash value, death benefit, premium charges, and policy loans.

AMENDED POLICY SCHEDULE
An amended policy schedule will be sent to you, the owner, and any irrevocable beneficiary upon a request to accelerate benefits and upon payment of this benefit. The schedule will show the reduced death benefit, cash value and premium amounts.

ACCELERATED BENEFIT
A benefit that may be requested by the owner if the insured is terminally ill, or if the insured is chronically ill. Terminal Illness and Chronic Illness are defined below.

MAXIMUM ACCELERATED DEATH BENEFIT
The sum of all accelerated benefit payments may not exceed the smaller of $250,000 or 80% of the face amount.

CONDITION OF PAYMENT
We will pay an amount up to the maximum accelerated death benefit if we receive proof that the insured (a) has been diagnosed with a terminal illness; or (b) is chronically ill. An administrative expense charge and an interest charge may apply at the time of acceleration.

DEFINITION OF TERMINAL ILLNESS
Terminal illness is considered a disease or illness that is expected to result in the death of the insured within twelve (12) months.

DEFINITION OF CHRONIC ILLNESS
Chronic illness is considered a disease or illness such that the insured is unable to perform at least two activities of daily living or requires substantial supervision as protections from threats to health or safety.

CERTIFICATION OF PHYSICIAN
The certification by a physician must include documentation supported by clinical, radiological, histological, or laboratory evidence of the condition.

PHYSICIAN OF OUR CHOICE
We may require an additional examination by a physician of our choice, and at our expense. If there is a conflict of medical opinion as to the life expectancy of the insured, a third medical opinion that is provided by a physician that is mutually acceptable to the insured and the company will govern.