

**All information must be provided to avoid delays. All questions are important, please read and complete each question.**

Proposed Insured (First Name, Initial, Last Name)  
\_\_\_\_\_

State of Birth \_\_\_\_\_ Country of Birth \_\_\_\_\_

Date of Birth \_\_\_\_\_ Present Age \_\_\_\_\_

Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Social Security No. \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_

Work Phone: \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Occupation \_\_\_\_\_

1. Have you used tobacco in any form in the past 12 months? .....  YES  NO
2. Are you a US Citizen including resident alien?  YES  NO  
If No, please explain type of visa or work permit: \_\_\_\_\_

**OWNER of Policy (if other than Proposed Insured)**  
\_\_\_\_\_

Relationship \_\_\_\_\_

Social Security No. \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

Plan Applied For:  SIMPL  MWL  
 OTHER \_\_\_\_\_

Classification:  Tobacco  Non-Tobacco

Face Amount \$ \_\_\_\_\_

Premium Amount \$ \_\_\_\_\_

Amount paid with application \$ \_\_\_\_\_

Premium Mode:

- Monthly Bank Draft  
Draft Day: \_\_\_\_\_
- Check here to draft first premium
- Monthly List Bill  Bi-Weekly
- Payroll Deduction  Quarterly
- Semi-Annual  Annual

Primary Beneficiary \_\_\_\_\_

Relationship \_\_\_\_\_

Street Address \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_

Relationship \_\_\_\_\_

Street Address \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

1. Does proposed Insured have existing life insurance policies or annuity contracts? .....  YES  NO
  2. Will this insurance replace or change any other insurance policies or annuity contracts? .....  YES  NO
- If "YES" to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required: \_\_\_\_\_

**Please read each question carefully and answer truthfully before signing application.**

**If the applicant answers YES to any question in Part 1, DO NOT PROCEED with the application.**

**Part 1**

	YES	NO
Do you currently have:		
1. Uncontrolled high blood pressure or uncontrolled diabetes, diabetic coma, insulin shock, or diagnosis of diabetes at age 9 or younger, or diabetes associated with retinopathy, nephropathy, neuropathy or amputation? .....	<input type="checkbox"/>	<input type="checkbox"/>
To the best of your knowledge and belief, have you:		
2. Ever been diagnosed with congestive heart failure, cystic fibrosis, Alzheimer's, senile dementia, dementia, two or more instances of internal cancer(s), Down 's syndrome, terminal illness, muscular dystrophy, Huntington's Disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS), or had an organ transplant, kidney dialysis, or hepatitis C?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been diagnosed or received treatment of Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex or tested positive for the Human Immunodeficiency Virus (HIV) virus? .....	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently or within the last 90 days:		
4. Been unable to care for yourself, bedridden at home, confined in a hospital, nursing home, hospice, assisted living or long-term care facility, or using oxygen? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Had undiagnosed chest pain, fainting, paralysis, coughed up or vomited blood? .....	<input type="checkbox"/>	<input type="checkbox"/>

**If the applicant answers YES to 1 or more questions in Part 2, he/she will be considered for the MWL Plan only.**

**Part 2**

To the best of your knowledge and belief, within the last 2 years have you 1) had, 2) been diagnosed for, 3) had or have any new symptoms for, or 4) awaiting surgery, medical tests or test results for:

	YES	NO
1. Heart attack, irregular heartbeat, aneurysm, any condition leading to angioplasty or bypass surgery, cardiomyopathy, cardiac defibrillator, heart valve surgery, stroke, cerebrovascular insufficiency or blockage? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Internal cancer, melanoma, leukemia, sickle cell anemia, renal insufficiency or failure, kidney disease (excluding passed kidney stones), liver disease including cirrhosis; chronic pancreatitis, Hodgkin's Disease, lymphoma, chronic lung disease including emphysema?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Paralysis, Parkinson's, Grand Mal epilepsy, multiple sclerosis, lupus or connective tissue disorder, organic brain disorder or suffer from mental retardation?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Schizophrenia, psychosis or suicidal thoughts or attempts, including hospitalization for major depression?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Alcoholism, drug abuse, narcotic addiction, or been convicted of felony? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently using a wheelchair or walker on a permanent basis?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Within the last one year, have you had an application for life insurance declined or refused for any reason? .....	<input type="checkbox"/>	<input type="checkbox"/>

Give Details to Questions Answered "YES" above: (Attach additional sheet, if necessary with applicant's signature) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

## This authorization complies with the HIPAA Privacy Rule

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 Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on LIBERTY BANKERS LIFE INSURANCE COMPANY'S or its reinsurers' behalf, 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). It is understood that LIBERTY BANKERS LIFE 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 redisclose it resulting in loss of protection by federal regulations.

I understand that:

- such information will be used by LIBERTY BANKERS LIFE INSURANCE COMPANY for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life 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 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 Life Underwriting Department of LIBERTY BANKERS LIFE INSURANCE COMPANY, P.O. Box 224 Brownwood, Texas 76804-0224. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

\_\_\_\_\_  
Proposed Insured (Please print)

\_\_\_\_\_  
SIGNATURE OF PRIMARY PROPOSED INSURED (IF AGE 15 OR OVER)  
OR PARENT OR GUARDIAN (JUVENILE APPLICATIONS)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Additional Proposed Insured (Please print)

\_\_\_\_\_  
Signature of Additional Person Proposed for Insurance

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Personal Representative designated by signature above is hereby authorized to execute this instrument based on: power of attorney, guardian-in-fact, guardian, payee, representative, other \_\_\_\_\_ (Circle one)

LBL-SIM-APP-0911-NC

### This Notice Must be Given to Proposed Insured

**FAIR CREDIT REPORTING ACT PRE-NOTIFICATION FORM.** Thank you for considering Liberty Bankers Life Insurance Company 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 Life Insurance Company, or its reinsurer(s), may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life and health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request from you, will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts, 02184, telephone 1-866-692-6901, web address: www.mib.com. Liberty Bankers Life Insurance Company, 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.

P.O. Box 224 Brownwood, TX 76804 1 (888) 525-4467

**Premium Payments as Easy as ABC**  
(Automatic Bank Checking)

**Save the Hassle.** With **ABC**, you let LBL and your financial institution handle your premium payments. Select the **ABC** option, and your future premiums will be withdrawn directly from your account and sent to us for timely processing.

**Authorization to Pay Future Monthly Premiums by ABC**  
(Automatic Bank Checking)

I authorize my Financial Institution to pay my insurance or annuity premiums through monthly checks, share drafts or electronic account debits drawn by and payable to Liberty Bankers Life Insurance Company. As my Financial Institution, you will be fully protected in honoring these payments until you receive written notice from me canceling this request.

Scheduled Payment Amount \$ \_\_\_\_\_ Scheduled Payment Dates: \_\_\_\_\_

Account Name: \_\_\_\_\_  Checking  Savings

Transit Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

Financial Institution Name & Address: \_\_\_\_\_

**I have paid the initial premium by check, please draft future payments on the scheduled payment date shown above after policy approval.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*

***Only complete this bottom section if NO premium has been collected!***

**FIRST PREMIUM BY BANK DRAFT**  
(Select one option to initiate your first premium draft)

1. \_\_\_\_\_ Bank Draft my account **IMMEDIATELY** upon receipt of this pending application, (initial here) and then on the scheduled payment date shown above after policy approval.
2. \_\_\_\_\_ Bank Draft my account only when the policy is **APPROVED** for issue and (initial here) thereafter on the scheduled payment date shown above.
3. \_\_\_\_\_ **WAIT** to Bank Draft my account on the **FIRST Scheduled Payment Date** (initial here) listed above following the policy approval.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



Administrative Office: P O Box 224  
Brownwood, Texas 76804  
1-800-604-8002

**AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION**

I hereby authorize any: medical practitioner, physician, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on LIBERTY BANKERS LIFE INSURANCE COMPANY'S or its reinsurers' behalf, 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, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that LIBERTY BANKERS LIFE 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 redisclose it resulting in loss of protection by federal regulations.

I understand that:

- such information will be used by LIBERTY BANKERS LIFE INSURANCE COMPANY for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life 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 Life Underwriting Department of LIBERTY BANKERS LIFE INSURANCE COMPANY, P. O. Box 224, Brownwood, Texas 76804. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Proposed Insured (Please print)

\_\_\_\_\_  
Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Additional Proposed Insured (Please print)

\_\_\_\_\_  
Signature of Additional Person Proposed for Insurance

\_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Personal Representative designated by signature above is hereby authorized to execute this instrument based on:  
power of attorney, guardian-in-fact, guardian, payee,  
representative, other \_\_\_\_\_(Circle one)

Please Check One



Liberty Bankers Life Insurance Company

The Capitol Life Insurance Company

**Replacement**

P.O. Box 224 · Brownwood, Texas 76804-0224 · 800-604-8002 · 325-643-4043 Fax

**IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?  Yes  No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?  Yes  No

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	<b>INSURER NAME</b>	<b>CONTRACT OR POLICY #</b>	<b>INSURED OR ANNUITANT</b>	<b>REPLACED (R) OR FINANCING (F)</b>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. (If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_

I certify that the responses herein are, to the best of my knowledge, accurate:

\_\_\_\_\_  
Applicant's Signature Printed Name Date

\_\_\_\_\_  
Producer's Signature Printed Name Date

I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:**

- Are they affordable?
- Could they change?
- You're older - are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:**

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

**INSURABILITY:**

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

**REPLACEMENT TRANSACTION  
SALES MATERIAL CERTIFICATION STATEMENT**

Print Producer Name and Number: \_\_\_\_\_

Print Applicant Name: \_\_\_\_\_

I hereby certify that:

- I used only insurer-approved sales materials;
- Copies of all sales materials used during solicitation were left with the applicant;
- Copies of all sales illustrations used during the solicitation were left with the applicant and also sent to the Home Office for the policy file; and
- This replacement is in compliance with the insurer's replacements guidelines.

\_\_\_\_\_  
Agents Signature

\_\_\_\_\_  
Date

I hereby certify that no sales materials or illustrations were used.

\_\_\_\_\_  
Agents Signature

\_\_\_\_\_  
Date