CHOICE MUTUAL
INSURANCE AGENCY

Final Expense Sample Application

This is a sample application, not a promise to issue coverage.

Important Notes:

You **cannot** buy this policy directly from Liberty Bankers Life.

This policy is **sold only via licensed Liberty Bankers Life agencies** such as Choice Mutual.

To apply, call us at 1-800-644-2926

Please read each question carefully and answer truthfully before signing application.
If "Yes" to any question in Part 1, STOP with the application.

Part 1 – Proposed Insured Must Answer All Questions.

	YES	NO
1. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:		
(a) 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)?	□	□
(b) Organ transplant (other than corneal), bone marrow transplant, stem cell treatment, kidney failure or dialysis, amputation due to diabetic complications, muscular dystrophy, mental incapacity, amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease, Downs's syndrome, cystic fibrosis, pulmonary fibrosis, or Huntington's disease?	□	□
(c) Diabetes at age 9 or younger?	□	□
(d) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, tested positive for human immunodeficiency viruses (HIV), or any other disorder of the immune system?	□	□
2. Have you, by a member of the medical profession, within the prior 2 years, been diagnosed with, or received, or been advised to receive treatment or medication for uncontrolled diabetes, uncontrolled high blood pressure, a diabetic coma or insulin shock, alcohol / drug abuse, illegal use of drugs, or dependency on prescription medication?	□	□
3. Within the last year, have you been confined to a hospital for more than 5 days total, been advised by a member of the medical profession to have surgery or hospitalization which you are still awaiting, 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?	□	□

If all "No" answers in Part 1, answer Part 2.

Part 2 – Proposed Insured Must Answer All Questions.

	YES	NO
4. Have you, by a member of the medical profession, within the prior 2 years, been diagnosed with, or received, or been advised to receive treatment or medication for:		
(a) Angina (chest pain), any type of heart or circulatory surgery, heart attack, or received a pacemaker or stent?	□	□
(b) Stroke (excluding Transient Ischemic Attack / TIA / mini-stroke) or paralysis?	□	□
(c) Lymphoma, leukemia or any form of 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) Chronic hepatitis, Hepatitis C, cirrhosis of the liver, chronic pancreatitis, kidney disease, or Systemic Lupus (SLE)?	□	□
(g) Multiple sclerosis, Parkinson's disease, or required the use of a walker, wheelchair, or electric scooter due to chronic illness or disease?	□	□
5. In the last two years, have you plead guilty to or been convicted of a felony or misdemeanor or do you have such a charge currently pending against you?	□	□

If any "Yes" answer(s) in Part 2, Proposed Insured may qualify for MWL (check state availability), answer Part 3.

Part 3 – Proposed Insured Must Answer All Questions.

	YES	NO
6. Have you by a member of the medical profession, ever been diagnosed with, or received, or been advised to receive treatment or medication for:		
(a) Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, emphysema, irregular heartbeat, atrial fibrillation, peripheral vascular disease or peripheral artery disease?	□	□
(b) Insulin use before age 25?	□	□
7. Have you, the Proposed Insured, by a member of the medical profession, within the prior 2 years, been diagnosed with, or received, or been advised to receive treatment or medication for epileptic seizures or a Transient Ischemic Attack (TIA/Ministroke)?	□	□

If all 'No" answers in Part 3, Proposed Insured may qualify for SIMPL Preferred.

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.

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SAMPLE
FROM FIDELITY MUTUAL

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].

SIMPLE FIRST CHOICE TERM

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.

SAMPLE
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