



Liberty Bankers Life

Insurance Company

**Application for
Medicare Supplement Insurance**

Idaho

Liberty Bankers Life Insurance Company

Speed up the processing by double checking the following:

- **Applicant's personal information completed**
(DOB, Gender, SSN, Medicare number/dates)
- **All dates completed**
(Effective dates, signature dates)
- **Replacement form completed**
(Termination reason marked, signed & dated)
- **Premium and payment information completed**
(Modal Premium listed, Bank information complete)
- **Prior coverage information completed**
(Carrier, plan, start & end dates)

Important Notice:

EFT Premium Payments will be drafted **upon issuance**

Application For: Medicare Supplement Coverage

Liberty Bankers Life Insurance Company
Administrative Office

PO Box 15357 • Clearwater, FL 33766-5357

Fax 1-855-493-9242 • Toll-free telephone 844-770-2400 • www.libertybankerslife.com

Writing Agent Name	Writing Agent #
--------------------	-----------------

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant. Use Section 9 if additional space is needed.

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


NOTE: If more than 1 applicant, complete Applicant B sections.

Applicant A	Applicant B
Medicare Supplement Plan Applied for: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan N	Medicare Supplement Plan Applied for: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan N
Requested Effective Date <u> </u> / <u> </u> / <u> </u> <small style="margin-left: 100px;">mo / day / yr</small>	Requested Effective Date <u> </u> / <u> </u> / <u> </u> <small style="margin-left: 100px;">mo / day / yr</small>
Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent	Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent
Calculated Premium (include app fee; HHD) \$ <u> </u> - \$ <u> </u> + \$ <u> </u> = \$ <u> </u> <small style="margin-left: 20px;">premium HHD app fee total</small>	Calculated Premium (include app fee; HHD) \$ <u> </u> - \$ <u> </u> + \$ <u> </u> = \$ <u> </u> <small style="margin-left: 20px;">premium HHD app fee total</small>
Select Premium Payment Option: <input type="checkbox"/> ACH Annual <input type="checkbox"/> Annual direct <input type="checkbox"/> ACH Semi-annual <input type="checkbox"/> Semi-annual direct <input type="checkbox"/> ACH Quarterly <input type="checkbox"/> Quarterly direct <input type="checkbox"/> ACH Monthly (direct monthly is not available)	Select Premium Payment Option: <input type="checkbox"/> ACH Annual <input type="checkbox"/> Annual direct <input type="checkbox"/> ACH Semi-annual <input type="checkbox"/> Semi-annual direct <input type="checkbox"/> ACH Quarterly <input type="checkbox"/> Quarterly direct <input type="checkbox"/> 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 <u> </u> + <u> </u>	State ZIP <u> </u> + <u> </u>
Mailing Address (if different from physical address)	Mailing Address (if different from physical address)
City	City
State ZIP <u> </u> + <u> </u>	State ZIP <u> </u> + <u> </u>

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
<input type="checkbox"/> Male <input type="checkbox"/> Female State of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No...
<p>Please reference your Medicare Card to complete the following questions.</p> 	
Medicare Health Insurance Card Claim Number (if known)	Medicare Health Insurance Card Claim Number (if known)
<p>To the Best of your Knowledge:</p> <p>1. Did you turn age 65 in the last 6 months?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Did you enroll in Medicare Part B in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please complete the following:</p> <p>Medicare Part A Effective Date: ____/____/____</p> <p>Medicare Part B Effective Date: ____/____/____</p>	<p>To the Best of your Knowledge:</p> <p>1. Did you turn age 65 in the last 6 months?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Did you enroll in Medicare Part B in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please complete the following:</p> <p>Medicare Part A Effective Date: ____/____/____</p> <p>Medicare Part B Effective Date: ____/____/____</p>

SECTION 3: HOUSEHOLD PREMIUM DISCOUNT INFORMATION.

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

1. Do you currently live with your legal spouse, including validly recognized civil union and domestic partners, or do you currently have a household resident (at least one, no more than 3) with whom you have continuously resided for the last 12 months who own or have been issued a Medicare Supplement policy from us?
2. If you answered "YES" to Question 1 above, please fill out the following information about the policyholder, 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

Policy Number

Name (First/Middle/Last)

Street Address

City/State/Zip

Policy Number

Name (First/Middle/Last)

Street Address

City/State/Zip

Policy Number

Application For: Medicare Supplement Coverage

SECTION 4. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge: 1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.) 2. Do you have another Medicare Supplement or Medicare Select insurance policy or certificate in force? (a) If "YES," with what company, and what plan do you have?	Applicant A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant B <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Applicant A	Applicant B	
Name of Company	Name of Company	
Plan	Plan	
Effective Date ___/___/_____	Effective Date ___/___/_____	
(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?..... (c) If "YES," indicate termination date..... (d) If "YES," have you received a copy of the replacement notice? (e) NOT INCLUDING Medicare Supplement, have you had before or do you now have any other Medicare plan coverage as referenced below? If you answer "NO" skip to question #4 below. If you answer "YES," please complete questions 3 (a-g) below. 3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. If you are still covered under this plan, leave "END" blank..... (a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?..... (b) If "YES," have you received a copy of the replacement notice?..... (c) Reason for termination/disenrollment? _____ (d) Planned date of termination/disenrollment? ___/___/_____	Applicant A <input type="checkbox"/> Yes <input type="checkbox"/> No ___/___/_____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Start ___/___/_____ End ___/___/_____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant B <input type="checkbox"/> Yes <input type="checkbox"/> No ___/___/_____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No Start ___/___/_____ End ___/___/_____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	_____ Applicant A	_____ Applicant B
	___/___/_____ Applicant A	___/___/_____ Applicant B

Application For: Medicare Supplement Coverage

SECTION 4. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below, CONTINUED

<p>(e) Was this your first time in this type of Medicare plan?</p> <p>(f) Did you drop a Medicare Supplement or Medicare select policy/certificate to enroll in this Medicare plan? If "YES,"</p> <p>(g) Is your former Medicare Supplement plan or Medicare select policy/certificate still available?.....</p> <p>4. Have you had coverage under any other health insurance within the past 63 days?</p> <p>(For example, an employer, union, or individual non-Medicare Supplement plan)</p> <p>(a) If "YES," with what company and what kind of policy/certificate? (List below.)</p>	<p>Applicant A</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Applicant B</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Applicant A	Applicant B		
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate
<p>(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank.</p> <p>(c) Reason for termination/disenrollment?</p> <p style="text-align: center;">_____ / _____</p> <p style="text-align: center;">Applicant A Applicant B</p> <p>(d) Planned date of termination/disenrollment?</p> <p style="text-align: center;">_____ / _____ / _____</p>	<p>Applicant A</p> <p>Start ____ / ____ / ____</p> <p>End ____ / ____ / ____</p>	<p>Applicant B</p> <p>Start ____ / ____ / ____</p> <p>End ____ / ____ / ____</p>	
<p>5. Are you covered for medical assistance through the state Medicaid program?.....</p> <p>(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",</p> <p>(a) Will Medicaid pay your premiums for this Medicare Supplement policy?.....</p> <p>(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?.....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>6. Producers shall list any other health insurance policies/certificates they have sold to the applicant.</p> <p>(a) List policies/certificates sold which are still in force.</p>			
Applicant A	Applicant B		
Name of Company	Name of Company		
Description of Benefits	Description of Benefits		
Effective Date of Coverage / /	Effective Date of Coverage / /		
(b) List policies/certificates sold in the past five (5) years which are no longer in force.			
Applicant A	Applicant B		

Application For: Medicare Supplement Coverage

If you are applying during Open Enrollment or Guaranteed Issue period, SKIP SECTIONS 5 and 6 and GO TO SECTION 7		
Height: ___ feet ___ inches Weight: _____ pounds	Height: ___ feet ___ inches Weight: _____ pounds	
In the past 12 months, have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No	In the past 12 months, have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION 5. HEALTH QUESTIONS - If either Applicant A or Applicant B answer "Yes" to any of the following questions 1-15, or to any of 16 B, C, D, or E that person is not eligible for Medicare Supplement Coverage.		
	Applicant A	Applicant B
1. Within the past 10 years, have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been advised by a physician that surgery may be required within the next 12 months for cataract(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been hospitalized two or more times within the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the past 10 years, have you had an organ transplant or amputation caused by disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past 10 years, 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 10 years, have you been diagnosed with Parkinson's disease, multiple sclerosis, ALS (amyotrophic lateral sclerosis), systemic lupus, or myasthenia gravis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 10 years, have you been diagnosed with, Alzheimer's disease, senile dementia or any other cognitive disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the past 10 years, have you been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC,) or Human Immunodeficiency Virus (HIV) infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. A. Within the past 10 years, have you been diagnosed with diabetes? If yes, within the past 10 years, have you been:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. advised by a medical professional to take more than 50 units of insulin daily or three or more medications (insulin and oral)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. diagnosed with retinopathy or neuropathy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. diagnosed with heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. treated for high blood pressure with three or more medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Application For: Medicare Supplement Coverage

SECTION 6. MEDICATION INFORMATION		
1. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please provide the details in the following table. Use Section 9 if additional space is needed.		
Applicant A <input type="checkbox"/> Yes <input type="checkbox"/> No (please attach a separate sheet if needed)		Applicant B <input type="checkbox"/> Yes <input type="checkbox"/> 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 effective date of coverage or on the date specified on this application.

I authorize Liberty Bankers Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes I authorize you, my financial institution, to pay from my account to "Liberty Bankers Life Insurance Company" any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

I would like my automatic monthly withdrawal to come from my (check one below) on the _____ day (must be between the 1st and 28th) of the month:

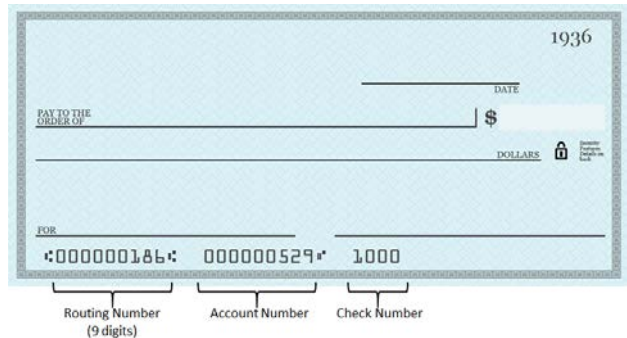
Checking

Please attach a voided check

Savings

Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.

- Payments cannot be postponed from the date selected.
- Payment from a third party, including any foundation, will not be accepted.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.



Financial Institution Name:

Phone #:

Financial Institution Address:

Transit Routing # (from left side of check)

Account # (from right side of check)

X _____
 Authorized Signature as Shown on Account

_____/_____/_____
 Date

X _____
 Authorized Signature as Shown on Account

_____/_____/_____
 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 reinstated, 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 reinstated 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 reinstated, 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I hereby authorize any medical practitioner, physician, hospital, clinic, pharmacy benefit manager, or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY (LBL) or its reinsurers information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, pharmacy prescription drugs, and/or drug, alcohol or tobacco usage of the applicant(s). I also authorize all said sources to give such records or knowledge to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on behalf of LBL. It is understood that LBL's underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I authorize MIB, Inc. to provide any medical or personal information that it has about me to LBL or any MIB-authorized third-party administrator performing underwriting services on LBL's behalf. I also authorize LBL, its reinsurer or authorized third-party administrator, to make a brief report of my protected health information to the MIB, Inc.

I understand that:

- such information will be used by LBL for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain Medicare Supplement insurance coverage;
- a picture copy or photocopy of this authorization shall be as valid as the original; and
- any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Underwriting Department of LBL, PO Box 15357, Clearwater, FL 33766-5357. I may inspect or copy any information used or disclosed under this authorization, if signed.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

To the best of my knowledge and belief, I wish to apply for a Medicare Supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by LBL.

Dated at _____, on _____ / _____ / _____
City State mo / day / yr **Applicant A's Signature**

Dated at _____, on _____ / _____ / _____
City State mo / day / yr **Applicant B's Signature**

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

LIBERTY BANKERS LIFE INSURANCE COMPANY
Medicare Supplement Administrative Office: PO Box 15357, Clearwater, FL 33766-5357

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Liberty Bankers Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits. No change in benefits, but lower premiums
- Fewer benefits and lower premiums.
- Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
- My plan has outpatient drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.

Other (please specify) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker or Other Representative

Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature

Date

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

LIBERTY BANKERS LIFE INSURANCE COMPANY
Medicare Supplement Administrative Office: PO Box 15357, Clearwater, FL 33766-5357

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:
 Medicare Supplement
 Plan A
 Plan F
 Plan G
 Plan N

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

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

to _____
(Applicant(s)),

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

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

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

Date

Signature of Producer

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

Name of Agency

Signature of Applicant

Address of Producer or Agency

Signature of Applicant B, if applying

Phone Number

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 SSN: _____

Producer Phone Number: _____

Producer Fax Number: _____

Comments: _____

This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Liberty Bankers Life Insurance Company and its affiliates. It may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, at 1-844-770-2400. We will arrange for you to return the original material to us via the US Postal Service and if requested, we will reimburse you for such expense.