Application for
Level Term Life Insurance

LIBERTY LIFE INSURANCE COMPANY, Greenville, SC

1. Applicant Information

Name______________________________
FIRST MI LAST

SSN____________________ ○ Male ○ Female

Marital Status ○ Married ○ Single ○ Sep. ○ Div. ○ Widow

State of Birth ____________ Date of Birth _____/_____/_____
MM DD YYYY

Height _______ Weight _______

Residence Address (PO Box not allowed) **(REQUIRED)**

____
ADDRESS

____
CITY STATE ZIP CODE

Mailing Address (*if different from Residence Address*)

____
ADDRESS

____
CITY STATE ZIP CODE

Email Address ____________________

Daytime Phone ( ) ____________________

Evening Phone ( ) ____________________

Do you have a Driver's License? ○ Yes ○ No

► Driver's License #________________ State of issue_________

► If "No," provide details. ____________________

Are you a United States Citizen? ○ Yes ○ No

► If "No," provide details. ____________________

Are you employed? ○ Yes ○ No

► If "Yes," what is your occupation? ____________________

► If "No," please explain. ____________________

Annual Income $____________________

2. Plan of Insurance

Face Amount $______________________

Level Term Base Plan
○ 10 Yr. ○ 15 Yr. ○ 20 Yr. ○ 30 Yr.

Premium Rate Class Applied For

Non-Tobacco	Tobacco
○ Preferred Plus	○ Preferred
○ Preferred	○ Standard Plus
○ Standard	○ Standard

CHECK (✓) WHICH APPLY. **FACE AMOUNT**

Optional Riders
○ Child's Rider $____________

Optional Benefits
○ Accidental Death $____________
○ Waiver of Premium

3. Primary Beneficiary(ies)

Name (First, MI, Last)	SSN/ Tax ID No.	Sex: Male	Sex: Female	Date of Birth MM / DD / YYYY	Relationship to Primary Insured	% Allocated (Must Total 100%)
1.						______%
2.						______%
3.						______%
4.						______%
5.						______%

4. Contingent Beneficiary(ies)

Name (First, MI, Last)	SSN/ Tax ID No.	Sex: Male	Sex: Female	Date of Birth MM / DD / YYYY	Relationship to Primary Insured	% Allocated (Must Total 100%)
1.						______%
2.						______%
3.						______%
4.						______%
5.						______%

Applicant Name ______________________________
FIRST MI LAST

5. Payor Information

Is the Applicant the Payor? ○ Yes ○ No

► If "No," complete the following:

Payor Name ______________________________
FIRST MI LAST

Relationship to Applicant ______________________________

SSN/TIN ____________________ Date of Birth ____/____/____
MM DD YYYY

Daytime Phone ( ) ______________________________

Evening Phone ( ) ______________________________

Residence Address (PO Box not allowed) **(REQUIRED)**

____
ADDRESS

____
CITY STATE ZIP CODE

Mailing Address *(if different from Residence Address)*

____
ADDRESS

____
CITY STATE ZIP CODE

Email Address ______________________________

6. Owner Information

Is the Applicant the Owner? ○ Yes ○ No

► If "No," complete the following:

Owner Name ______________________________
FIRST MI LAST

Relationship to Applicant ____________________ ○ Male ○ Female

SSN/TIN ____________________ Date of Birth ____/____/____
MM DD YYYY

Daytime Phone ( ) ______________________________

Evening Phone ( ) ______________________________

Residence Address (PO Box not allowed) **(REQUIRED)**

____
ADDRESS

____
CITY STATE ZIP CODE

Mailing Address *(if different from Residence Address)*

____
ADDRESS

____
CITY STATE ZIPCODE

Email Address ______________________________

7. Children Proposed for Coverage

Name (First, MI, Last)	SSN	Sex		Height	Weight	State Of Birth	Date of Birth MM / DD / YYYY
		Male	Female				
1.		☐	☐				
2.		☐	☐				
3.		☐	☐				
4.		☐	☐				
5.		☐	☐				
6.		☐	☐				

8. Payment Information

Select One (1) Billing Method:

○ Monthly Bank Draft (EFT)
(Please complete EFT authorization.)

○ Direct Billing *(Select frequency.)*
○ Semi-Annual
○ Annual

Total Premium $______________

Select Payment Method For Initial Premium:

○ Check

○ Credit Card
(Complete Credit Card Authorization.)

Amount Submitted with Application $______________

Applicant Name ______________________
FIRST MI LAST

GENERAL QUESTIONS

1. (1.1) For Applicant, give full details in space provided:
a. Name of Personal Physician
b. Address and Phone Number of Personal Physician
(*Street, City, State, Zip Code*)

(1.2) For any Children Proposed for Coverage, give full details in space provided:
a. Name of Personal Physician
b. Address and Phone Number of Personal Physician
(*Street, City, State, Zip Code*)

Please provide complete details to "Yes" answers in space provided.

Details to "Yes" answers

2. (2.1) In the past ten (10) years, has any Proposed Insured been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; required follow-up for; or had any known indication of: disease or disorder of the heart, lung, kidney, liver, brain, or nervous system; diabetes; stroke; or cancer? ○ Yes ○ No

(2.2) Has any Proposed Insured been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of his or her immune system, or had a positive HIV test? ○ Yes ○ No

3. In the past year, has any Proposed Insured used any form of tobacco or nicotine-based products? ○ Yes ○ No
► If "Yes," indicate type(s), date last used, and quantity per day.

4. In the past five (5) years, has any Proposed Insured:
(4.1) engaged in flying as a pilot, student pilot, or crew member? ○ Yes ○ No

(4.2) engaged in ballooning, parachuting, hang gliding, skydiving, vehicle racing, scuba diving below 50 feet, mountain climbing, or any other similar avocation? ○Yes ○ No

5. Does any Proposed Insured have future plans to engage in any of the activities listed in question four (4)? ○ Yes ○ No

6. In the past five (5) years, has any Proposed Insured had a driver's license suspended or revoked, been charged with a DUI/DWI, had two (2) or more moving violations, or had an accident while operating a motor vehicle? ○ Yes ○ No

7. Has any Proposed Insured ever been arrested for, convicted of, or pleaded "guilty" or "no contest" to any felony? ○ Yes ○No

8. In the past 12 months, has any Proposed Insured traveled outside of the United States or Canada, or does any Proposed Insured have plans to do so in the next 12 months? ○ Yes ○ No

9. Will this insurance replace any other life insurance or annuity? ○ Yes ○No
► If "Yes," submit required replacement forms.

10. Has anyone applying for coverage ever had a life, accident or health insurance application rated, declined or withdrawn by Liberty Life Insurance Company or any other company? ○Yes ○No

11. Does any Proposed Insured have an application or informal inquiry for life insurance pending with any other company or society, or has any Proposed Insured ever withdrawn such application or informal inquiry? ○ Yes ○ No

Applicant Name ______________________________
FIRST MI LAST

ACKNOWLEDGMENT

By signing below, each person applying for coverage understands, represents, and agrees that:

The statements and answers made in this application are true and complete and are made to obtain the insurance applied for. No insurance shall take effect under this application unless and until all of the following conditions have occurred while the Proposed Insured(s) is/are alive and the health and all other conditions affecting the insurability of such person(s) remain as stated in the application: (1) all medical examinations, tests, x-rays, electrocardiograms, and medical questionnaires required by the rules and standards followed by Liberty Life Insurance Company (the "Company") have been completed; and (2) as of the date of the application, each Proposed Insured is insurable under the rules and standards followed by the Company for the plan, rating class, premium rate, and amount of insurance applied for; and (3) the first full initial premium has been paid. No one except Company Home Office officers can make, change or discharge any insurance contract, or bind the Company by making any promises about any policy benefits applied for.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize any insurance company or reinsurer, the Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, employer or other organization, institution or person to disclose to Liberty Life Insurance Company's (the "Company") insurance administrators, underwriting personnel, claims personnel, investigators, legal counsel, and reinsurers, the following information pertaining to me or any of my minor children proposed for coverage: information relating to employment, other insurance coverage, prescribed drugs, past and present physical, mental, drug and/or alcohol conditions, motor vehicle records, avocations, general reputation, and other personal characteristics.

I understand that the Company may collect this information for the purpose of determining eligibility for insurance and investigating claims for benefits. I further understand and agree that the Company may disclose all or some of my information to its insurance administrators, its reinsurance companies, its agents, the MIB, and other persons or organizations performing business or legal services in connection with my application.

This authorization shall be valid for 24 months. I understand that I may receive a copy of this Authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by notifying the Company in writing, subject to state law and the rights of anyone who has relied on this authorization. I further understand that such revocation may cause the Company to reject my application.

Date and Signed at ______________________________ on ____________________ 20__________
City and State Month Day

✗ ______________________________ ____________ ✗ ______________________________ ____________
Signature of Applicant Date Signature of Owner (*if not Applicant*) Date

Agent's Statement: I have truly and accurately recorded the information given by the Proposed Insured(s) or Applicant.

To the best of my knowledge, the policy applied for ☐ does ☐ does not involve replacement of any life insurance or annuity.
If replacement is involved, appropriate forms are being submitted.

✗ ______________________________ ____________ ✗ Mark L. Roden ____________
Signature of Writing Agent *(as Witness)* Date Printed Name of Writing Agent (Required) Date

Applicant Name ______________________
FIRST MI LAST

WRITING AGENT INFORMATION

Agent/Representative's Printed Name ✗ Mark L. Roden

Email Address mroden@mc2health.com

Phone Number (972) 898-8063 Fax Number (866) 402-3483

Agency Office/Broker-Dealer Name ______________________ Agent Account/Broker No. 447664321

Agency Office/Broker-Dealer Address 6021 Morriss Road #113

Flower Mound, TX 75028

Remarks ______________________

Is this a Companion Policy? ○ Yes ○ No

Name on Associated Application ______________________

HOME OFFICE AMENDMENT(S)

(NOT APPLICABLE IN PENNSYLVANIA AND WEST VIRGINIA)

APPLICATION FOR INSURANCE PART II — LIBERTY LIFE INSURANCE COMPANY, Greenville, SC

Name ________________________________ Date of Birth ___/___/_____ Social Security No. _______________

FIRST MI LAST — MM / DD / YYYY

Give full details to Yes answers, including specific diagnoses, results, dates of onset and recovery, and names and addresses of all healthcare professionals and medical facilities. ***(Attach additional sheet[s] if necessary.)***

Question	Answer	**Details to Yes Answers**
1. In the past ten (10) years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; required follow-up for; or had any known indication of:		
a. high blood pressure, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, heart failure, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	○ Yes ○ No	
b. epilepsy, seizures, tremors, dizziness, headaches, fainting spells, stroke, paralysis, head injury, memory loss, Alzheimer's disease, dementia, or any other disease or disorder of the brain or nervous system?	○ Yes ○ No	
c. diabetes or any disease or disorder of the pituitary, thyroid, parathyroid, or adrenal glands?	○ Yes ○ No	
d. leukemia, lymphoma, tumor or any other form of cancer or malignancy?	○ Yes ○ No	
e. anemia, polycythemia, clotting or platelet disorder, or any other disease or disorder of the blood or spleen?	○ Yes ○ No	
f. cyst, polyp, lump, or other growth, or any disease or disorder of the breast, skin, or lymph nodes?	○ Yes ○ No	
g. asthma, bronchitis, emphysema, COPD, pneumonia, sarcoidosis, sleep apnea, tuberculosis, shortness of breath, persistent hoarseness or cough, coughing up blood, or any other disease or disorder of the lung or respiratory system?	○ Yes ○ No	
h. hepatitis, ulcer, blood in stool, colitis, or any other disease or disorder of the stomach, esophagus, liver, pancreas, gallbladder, intestines, colon, or rectum?	○ Yes ○ No	
i. protein, blood, or sugar in the urine, or any disease or disorder of the kidney, bladder, prostate, or reproductive system?	○ Yes ○ No	
j. arthritis, lupus, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the muscles, connective tissues, or bones?	○ Yes ○ No	
k. anxiety, depression, schizophrenia, bipolar disorder, or any other mental or nervous disorder?	○ Yes ○ No	
l. any disease or disorder of the eyes, ears, nose, or throat?	○ Yes ○ No	
2. In the past year, have you used any form of tobacco or nicotine-based products? (If Yes, indicate type[s], date last used, and quantity per day.)	○ Yes ○ No	
3. Have you been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of your immune system, or had a positive HIV test?	○ Yes ○ No	
4. Have you lost more than ten (10) pounds in the last year? (If Yes, give reason.)	○ Yes ○ No	
5. To the best of your knowledge, are you now pregnant? (If Yes, provide number of months.)	○ Yes ○ No	

6. a. Are you currently taking any medications (prescription, injection, over the counter) or herbal remedies? (If Yes, list the medication[s]/remedy[ies] with dosage[s] in space provided below.) ○ Yes ○ No

b. In the past two (2) years, have you been advised to take any medications (prescription, injection, or over the counter) other than already disclosed in question 6.a.? (If Yes, list the medication[s] with dosage[s], and the name of the condition for which you are taking this medication.) ○ Yes ○ No

MEDICATION/ HERBAL REMEDY	DOSAGE	CONDITION	CURRENTLY TAKING?	MEDICATION/ HERBAL REMEDY	DOSAGE	CONDITION	CURRENTLY TAKING?
______	______	______	○ Yes ○ No	______	______	______	○ Yes ○ No
______	______	______	○ Yes ○ No	______	______	______	○ Yes ○ No
______	______	______	○ Yes ○ No	______	______	______	○ Yes ○ No

APPLICATION FOR INSURANCE PART II **LIBERTY LIFE INSURANCE COMPANY, Greenville, SC**

Name ______________________________ Date of Birth ___/___/_____ Social Security No. ______________
FIRST MI LAST MM / DD / YYYY

Give full details to Yes answers, including specific diagnoses, results, dates of onset and recovery, and names and addresses of all healthcare professionals and medical facilities. ***(Attach additional sheet[s] if necessary.)***

Details to Yes Answers

7. Do you consume alcoholic beverages? (If Yes, provide amount and frequency.) ○ Yes ○ No

8. Have you:

a. ever used heroin, cocaine (including crack), LSD, PCP, amphetamines, barbiturates, any derivative of these drugs, or any other controlled substance except as prescribed to you by a healthcare professional licensed to prescribe controlled substances? ○ Yes ○ No

b. ever been arrested for, convicted of, or pleaded “guilty” or “no contest” to drug possession or distribution? ○ Yes ○ No

c. attempted suicide or sought counseling for suicide prevention or for thoughts about suicide? ○ Yes ○ No

d. received or been advised by a healthcare professional to receive treatment or counseling for alcohol or drug use? ○ Yes ○ No

e. been advised by a healthcare professional to reduce or stop alcohol or drug use? ○ Yes ○ No

f. been a member of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)? ○ Yes ○ No

9. Have you requested or received any Worker’s Compensation, Social Security, sickness or disability benefits or compensation? ○ Yes ○ No

10. During the past five (5) years, have you:

a. been advised to have any diagnostic test, surgery, or hospitalization which has not been completed? ○ Yes ○ No

b. had surgery, or been admitted to any medical facility for any condition not disclosed in the preceding questions? ○ Yes ○ No

c. consulted, been examined, or been treated by any healthcare professional for any condition not disclosed in the preceding questions? ○ Yes ○ No

11. Have your natural parents, brother(s) or sister(s) been diagnosed with or died from any of the following conditions prior to age 60? (Check 3all that apply.) ○ Yes ○ No

○ cancer ○ diabetes ○ stroke ○ high blood pressure
○ heart attack, heart failure, or any other cardiovascular disease
(If Yes, please provide full details.)

RELATIVE	CONDITION(S) SUFFERED	AGE AT ONSET	AGE AT DEATH

12. Do you have a personal physician? ○ Yes ○ No

a. Name ______________________________
b. Street ______________________________
c. City/State/Zip Code ______________________________
d. Telephone # (   ) ______________________________
e. Date and reason for last consultation ______________________________

I represent that the statements and answers given in this Application Part II are true, complete, and correctly recorded.

Signed at: ______________________________
CITY STATE

✗ ______________________________
SIGNATURE OF THE PROPOSED INSURED DATE

✗ ______________________________
SIGNATURE OF THE EXAMINER, BROKER OR WITNESS DATE

Authorization for Release of Health Information to Liberty Life Insurance Company ("Company")

______________________________________   _____/_____/_____

Name of Proposed Insured (Please Print)   Date of birth

I, the undersigned person, authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Company, its agents, employees, representatives and reinsurers. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I also authorize any insurance company, the Medical Information Bureau, or other organization, institution, or person ("Other Persons") that has any records or knowledge of me or my health, to give to the Company, its agents, its employees, its representatives and its reinsurers any such information. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

This protected health information is to be disclosed under this Authorization so that the Company may: (1) underwrite my application for coverage, make risk rating determinations and make policy issuance determinations; (2) obtain reinsurance; and (3) conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to Liberty Life Insurance Company, PO Box 19078, Greenville, SC 29602-9078. I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I also understand that if I refuse to sign this Authorization, the Company may not be able to process my application. I understand that I have a right to receive a copy of this Authorization.

______________________________________   ______________________________________

Proposed Insured or Personal Representative   Date

____

Description of Personal Representative's authority or relationship to Proposed Insured.

Liberty Life Insurance Company
PO Box 789 Greenville, South Carolina 29602-0789

RECEIPT

The amount of $_________________ has been collected with the application for insurance with Liberty Life Insurance Company on ____________________________, dated ________.
Proposed Primary Insured

WHEN COVERAGE TAKES EFFECT

No insurance shall take effect under your application unless and until all of the following conditions have occurred while the Proposed Insured(s) is/are alive and the health and all other conditions affecting the insurability of such person(s) remain as stated in the application:

1. All medical examinations, tests, x-rays, electrocardiograms, and medical questionnaires required by the rules and standards followed by Liberty Life Insurance Company (the "Company") have been completed; and
2. As of the date of the application, each Proposed Insured is insurable under the rules and standards followed by the Company for the plan, rating class, premium rate, and amount of insurance applied for; and
3. The first full initial premium has been paid.

If all of these conditions are met, the insurance shall be as provided according to the terms and conditions of the policy applied for. No one except Company Home Office officers can make, change or discharge any insurance contract, or bind the Company by making any promises about any policy benefits applied for.

All checks must be made payable to the Company.
Do not make checks payable to the agent or leave the payee blank.

____
Signature of Proposed Insured

____
Signature of Owner or Applicant if not Proposed Insured

____
Date

____
Signature of Agent

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

MEDICAL INFORMATION BUREAU, INC. NOTICE

Liberty Life Insurance Company, its third-party administrators, or its reinsurers may make a brief report to the Medical Information Bureau, Inc. ("MIB") concerning factors that affect the insurability of any person for whom coverage is being requested. The MIB is a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB 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 and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is: P.O. Box 105, Essex Station; Boston, Massachusetts 02112, telephone number (617) 426-3660, fax number (781) 461-2453.

Liberty Life, its third-party administrators, or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits has been submitted.

CONSUMER REPORT NOTICE

In compliance with the Fair Credit Reporting Act, (the "Act"), we are informing you that as part of our routine procedures an investigative consumer report including information as to character, general reputation, personal characteristics and mode of living may be made. Under the Act, you have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation, to request a personal interview in connection with the investigative consumer report, and to receive a copy of the report. The investigation (which may include personal interviews) concerns residence verification, marital status, number of children, economic status, employment, occupation, general health, habits, reputation and mode of living. If the application is for family insurance or any other type insurance on spouse or minor child, this notice is also being given to you as the representative of said spouse or minor child named in the application. You may also request from the consumer reporting agency a written summary of your rights under the Fair Credit Reporting Act.

NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you. Some will come from other sources. That information and any information collected by us later may, in certain circumstances, be disclosed to third parties without your specific permission. We will also make such other disclosures as are permitted by law. You may access and request corrections to the information we collect about you. We hope that you will find this description of our information practices to be helpful. We take our responsibilities and your rights very seriously. A more detailed description of our information practices will be provided to you.

Life Replacement Form

Liberty

Liberty Life Insurance Co. PO Box 789 Greenville, SC 29602-0789

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

________________	________________	________________
Applicant's Signature	Date	Agent's Signature

The following policy(ies) may be replaced as a result of this transaction:

Insurer	Insured	Contract No.

Copies to: Applicant, Replacing Insurer, Existing Insurer

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

Liberty Life Insurance Company, PO Box 19084, Greenville SC 29601-19084 1 (866) 765-4555

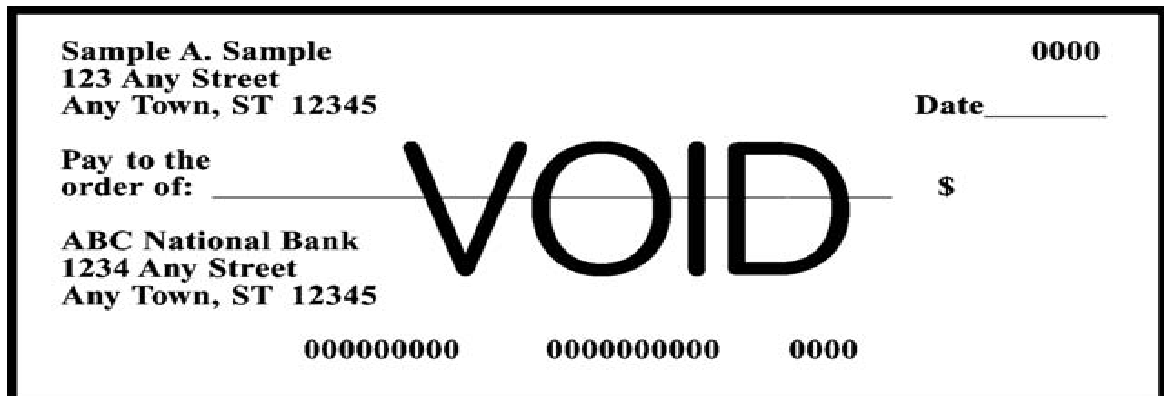
For the purpose of paying premiums, I authorize Liberty Life Insurance Company to electronically draft debits from my account at

____
(Financial Institution)

I request and authorize my financial institution to pay and charge to my account electronic debits drawn on my account, by and payable to Liberty Life Insurance Company, provided there are sufficient funds in my account at the time the debit is made. I agree that Liberty Life's rights, in respect to each electronic debit, shall be the same as if it were a check drawn on my account and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until the financial institution actually receives such notice. I also agree that the financial institution shall be fully protected in honoring any such debit. I further agree that if any such electronic debits are dishonored, whether intentionally or inadvertently, the financial institution shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

I understand that my premium due date will not change and the electronic debit drawn on my account will occur no earlier than the due date and no later than two business days after the due date.

PLEASE ATTACH VOIDED CHECK HERE.



☐ Please draft both my initial premium payment and my regular payments.

☐ Please draft my regular premium payments only.

Please draft my payments on the __________ day of each month.

____ ________________________________
City and State *Date*

____ ____
Signature – Same as account *Additional Signature if joint account*

048-1188i (10-06)

CREDIT CARD AUTHORIZATION FORM

Optional Credit Card Authorization for Premium Billing

I have completed an application for term life insurance from Liberty Life Insurance Company. I authorize Liberty Life Insurance Company to charge my credit card as indicated for the initial premium only.

____

Name of Proposed Insured

[ ] VISA [ ] MasterCard

Credit Card Account Number: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___

Expiration Date: ____/____
Mo. Yr.

____

Print Name (as it appears on credit card)

Cardholder billing address (if different from home address of proposed insured)

____

____

____

____

Cardholder Signature Date Signed

The initial payment is considered paid at the time of application provided the charge is accepted by the issuing credit card company.

To be completed by Home Office: __________________________________
(Policy Number)