*Application to Liberty Bankers Life Insurance*
*P.O. Box 224 Brownwood, TX 76804*

*Supplemental Application for:*
*Children or Grandchild Rider*

| **1. Supplement to Application on :** | | | **Check Appropriate Rider** | |
|---|---|---|---|---|
| **Proposed Insured:** | **Application Date:** | **Policy # (When adding existing rider)** | **Child Rider # of units** ◯ | **Grandchild Rider $7,500** ◯ |
| **Address** | **City** | **State** | **Zip Code** | |

**2. Children/Grandchild Proposed for Insurance (Please Print)**

*Name all natural-born children, stepchildren and legally adopted children or grandchildren for grandchild rider of Primary Proposed Insured who have not attained age 18. Insurance will not be provided on newborn children less than 15 days of age or grandchildren if grandchild riders applied for.*

| Full Name of Proposed Insured Child/Grandchild | Age Last Birthday | Sex | Date of Birth | Relationship to Proposed Insured | Height | Weight |
|---|---|---|---|---|---|---|
| **A.** | | | | | | |
| **B.** | | | | | | |
| **C.** | | | | | | |

**3. Health Information**

1. Has any Proposed Insured Child/Grandchild ever had, been diagnosed or treated for cancer, diabetes, heart or circulatory disorder, mental or nervous disorder, mental retardation, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, un-operated heart defects, epilepsy, asthma, disorders of the muscles or bones, anemia or other disorders of the blood, bladder, kidneys, liver or lungs?..... ◯Yes ◯No
2. Has any Proposed Insured Child/Grandchild ever had, been diagnosed or received treatment of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex or tested positive for the Human Immunodeficiency Virus (HIV) virus ?..... ◯Yes ◯No
3. Has any Proposed Insured Child/Grandchild ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?..... ◯Yes ◯No

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

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

**Beneficiary Designation:**
*Any proceeds payable under this rider will be paid to the Owner, if living. Otherwise, per the beneficiary provision of the rider.*

1. Does Proposed Insured Child/Grandchild 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:_____

I declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application
Dated at _____, _____ on this _____ day of _____, _____.

Signature of Grandparent/Parent Guardian _____ ***(e-signed)***

***The electronic signature(s) above fully comply with the Federal Electronic Signature status, Title 15, U.S.C., Chap. 96, Sec. 7001, et seq., and is therefore fully legal and valid as an original signature.***

**Agent Statement:**

1. Does the Proposed Insured have any existing life insurance policies or annuity contracts?..... ◯YES ◯NO
2. Is replacement of existing insurance involved in this application? If yes: Have you submitted the appropriate replacement forms?..... ◯YES ◯NO

X _____ _____ ***(e-signed)*** _____

Printed Agent's Name | Agent's Signature | Agent's Number