DISCLOSURES *for* PAPERLESS APPLICATION PROCESS – GENERIC

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**). 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.**

In addition, included is a conditional receipt should you collect the correct first premium mode.

This Notice Must be Given to Proposed Insured

FAIR CREDIT REPORTING ACT PRE-NOTIFICATION FORM. Thank you for considering Liberty Bankers/The Capitol 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/The Capitol Life Insurance Company, 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/The Capitol 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.

CONDITIONAL RECEIPT – (Cross through if payment is NOT received).

NO INSURANCE WILL BECOME EFFECTIVE PRIOR TO DELIVERY, UNLESS THE FOLLOWING CONDITIONS HAVE BEEN FULFILLED EXACTLY: INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ONLY IF THESE CONDITIONS ARE MET:

1. That on the effective date the Proposed Insured is insurable as a standard risk under the Company's rules for the plan amount and premium rate applied for.
2. That the sum paid is equal to the FULL FIRST PREMIUM for the policy applied for.

INSURANCE ISSUED BASED ON THE APPLICATION WILL TAKE EFFECT ON THE LATEST OF:

(a) date of the application; or (b) date requested in the application; or

(c) date of the last of any medical examinations or tests required under the rules and practices of the Company.

The total amount of insurance which may become effective prior to delivery of the policy to the Owner shall not exceed $25,000. This amount includes LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS then IN FORCE or APPLIED FOR with this Company. **LIBERTY BANKERS/THE CAPTIOL LIFE INSURANCE COMPANY** has received $ _____ for Applicant _____ _____

X_____ _____

Agent's Signature Date

THE PREMIUM CHECK MUST BE MADE PAYABLE TO LIBERTY BANKERS/THE CAPITOL LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Liberty Bankers Life
Insurance Company

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, 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 MIB, Inc., 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 re-disclose it resulting in loss of protection by federal regulations. I authorize LIBERTY BANKERS LIFE INSURANCE COMPANY, or its reinsurers, to make a brief report of my protected health information to the MIB, Inc.

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)