This is only a sample application. It is not a promise to issue coverage.

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

It is **sold only via licensed agencies** such as Choice Mutual.

To apply, call Choice Mutual
(licensed to sell from Liberty Bankers Life products)
at 1-800-644-2926.

Liberty Bankers Life
The Capitol Life

☐ ☐ Check Appropriate Company

Final Expense Pre-Qualifying Worksheet

PO Box 224 Brownwood, Texas 76804-0224 • 1-888-525-4467 • FAX 1-888-525-5002 • E-Mail: newbiz@lbladmin.com

This worksheet is necessary to initiate underwriting. Please complete all information before you call DIMA. Once form is completed, please call 800-604-6844 for the application and approval completion process. Agent, Insured, (Owner and/or Payor, if different) must be on the phone at the time of the call. This worksheet contains sensitive information and should be kept secured for your records or destroyed. Do not send in this form.

Agent: _____ **Agent Number** _____ **Date:** _____

POSTI Reference #: _____ **Issue State:** _____ **Telesales application** ☐ **YES** ☐ **NO**

Proposed Insured Full Name:

_____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

State of Birth _____ Country of Birth _____

Social Security No. or ITIN _____

Have you used tobacco, nicotine, or e-cigarettes in any form in the past 12 months? ☐ YES ☐ NO

Name and City of Doctor: _____

Are You Currently Disabled? ☐ YES ☐ NO

If Yes, Please provide details:: _____

****

Street Address _____

City, State, Zip _____

Home/Cell Phone _____

Work Phone _____

Plan- Riders Applied For:

Face Amount $_____

__ SIMPL Preferred __SIMPL Standard ___MWL

__ AD&D ___(units) CTIR ___Grandchild Rider

Premium Amount $_____ Premium Mode:

☐ Monthly Bank Draft **OR**
☐ Quarterly ☐ Semi-Annual
☐ Annual Amount Paid with Application $_____

OWNER OF POLICY IF NOT INSURED:

_____

Relationship _____

Social Security No. _____

Address _____

Home/Cell Phone _____

☐ **Check here to draft first premium**

Bank Draft Date Each Month

☐ 1st **of Month** ☐ 3rd **of Month**

☐ 2nd **Wednesday** ☐ 3rd **Wednesday**

☐ 4th **Wednesday** ☐ **Other Date:** _____

Primary Beneficiary _____

Relationship _____

Home/Cell Phone _____

Contingent Beneficiary _____

Relationship _____

Home/Cell Phone _____

Name as it Appears on Bank Acct:

_____

Acct. # _____

Routing #: _____

Bank Information Name of Financial Institution:

_____

City: _____

State: _____

FOR AGENTS USE ONLY!

Replacement Information: (Replacement not allowed for tele-sales) YES NO

1. Does proposed Insured have existing life insurance policies or annuity contracts? ☐ ☐
2. Will this insurance replace or change any other insurance policies or annuity contracts? ☐ ☐

If "Yes" to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required: _____

Use the following health questions to decide which Final Expense plan to offer

If the applicant answers "Yes" to any question in Part 1, DO NOT PROCEED with the application.

Part 1 YES NO

Have you ever been diagnosed have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

1. 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)? ☐ ☐
2. Organ transplant (other than corneal), untreated Hepatitis C, kidney failure or dialysis, amputation due to diabetic complications, multiple sclerosis, muscular dystrophy, mental retardation, amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease, Downs's syndrome, cystic fibrosis or Huntington's disease? ☐ ☐
3. Diabetes at age 9 or younger? ☐ ☐
4. AIDS, AIDS Related Complex, tested positive for HIV virus or any other disorder of the immune system? ☐ ☐

Within last 2 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

5. Uncontrolled diabetes or uncontrolled high blood pressure? ☐ ☐

Within the last year have you:

6. Been confined to a hospital, been advised by a member of the medical profession to have surgery or hospitalization, used oxygen due to a medical condition, been unable to care for yourself or been prescribed bed rest by a member of the medical profession at home or in a nursing home, hospice, long-term care or assisted living facility? Definition of assisted living: requires help in at least one area of skills considered necessary for living and caring for oneself (feeding, dressing or bathing) ☐ ☐

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

Part 2 Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.

YES NO

Within the past 2 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

(a) Angina (chest pain), any type of heart or circulatory surgery, heart attack, or received a pacemaker or stent? ☐ ☐
(b) Stroke, Transient Ischemic Attack (TIA/mini-stroke) or paralysis? ☐ ☐
(c) 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) Alcohol or drug abuse, have you used illegal drugs or been convicted of felony or on parole? ☐ ☐
(g) Used a walker, wheelchair or electric scooter due to chronic illness or disease? ☐ ☐

If all "No" answers in Part 2, complete Part 3. Otherwise, select MWL & check for state availability.

Part 3 Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.

YES NO

Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

(a) Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, emphysema, peripheral vascular disease or peripheral artery disease? ☐ ☐
(b) Chronic hepatitis, Hepatitis C, cirrhosis of the liver, chronic pancreatitis, liver disease or kidney disease? ☐ ☐
(c) Insulin use before age 25? ☐ ☐
(d) Irregular heartbeat, atrial fibrillation, Systemic Lupus (SLE), epileptic seizures, Parkinson's disease? ☐ ☐

If all 'No" answers in Part 3, select SIMPL Preferred. Otherwise, select SIMPL Standard.

AGENT NOTES: