Final Expense Paperless Application Process Instructions

Agents will no longer be required to fill out an application, HIPAA and Disclosure Forms, Bank Draft or Direct Express Forms and submit these to new business! **It's EZ as 1 - 2 – 3!**

1. **The Agent** makes the final expense sale with client. Using the ***application worksheet, Child/Grandchild Supplemental Application,*** along with the ***Disclosure Form***, the Agent should:
    a. Pre-Qualify the client, and Children and/or Grandchildren (if applicable), for the correct plan using the health questions as a guideline.
    b. Gather important client personal, Bank, or Direct Express account information.
    c. Have all the required disclosures, including HIPAA, to read and give the client in one easy detached form. Included is a conditional receipt should you collect the first premium!

2. **Once worksheet is completed and disclosures read, the Agent** will make the call to **DIMA** (800-604-6844) to initiate the Point of Sale Telephone Interview **(POSTI)** for instant underwriting decision ***AND*** application paperwork completion! Information from the worksheet, and Child//Grandchild Supp App (if applicable) will be required during this interview from the agent. ***Complete and accurate data will make the call smooth and timely.***

    Please Note: By eliminating the need to fill out and then send in all paperwork, the time will more than offset the few additional minutes required in the paperless process. The worksheet will allow an agent to have important client and bank information readily available for the Telephone Interview.

    DIMA will begin the process as follows:
    a. Ask the Agent client personal and Bank (Direct Express if used to pay premiums) information.
    b. Speak with your client to obtain, verify, and underwrite the sale. This includes:
        i. Verify disclosures have been read or given to client, including MIB and HIPAA.
        ii. Obtain voice signatures for disclosures and application.
        iii. Verify health questions (same as worksheet).
        iv. Complete Application and all required Forms.
        v. Give the Agent an **instant underwriting decision** before you hang up!
        vi. Instruct DIMA where the policy should be sent: To the Agent or Client.

3. **The Agent** retains the worksheet for their record**……..**NO need to send in anything and the client's policy will be issued. **EXCEPT FOR THE FOLLOWING:**
        a. **If the sale is a replacement:** The proper state required replacement form(s) must be completed and signed prior to the call to DIMA.
        b. **Alabama:** Alabama Arbitration Disclosure Form (#CLIC-ARB-AL)
        c. **California:** Medical Eligibility Disclosure (#7404.4-0505) Home Meeting Disclosure for 65 & Over (7404.2-0505) Financial Product Disclosure 65 & Over (7404.3-0505)
        d. **Pennsylvania:** Disclosure Statement (LBL PA DIS (0806)

Agent must note POSTI reference # on the upper right corner for any required form and fax to new business @888-525-5002. Failure to do so will delay policy issue and commissions paid.

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

Complete this worksheet in order to collect important applicant information BEFORE you call DIMA. Once you complete this form, please call 800-604-6844 for the application and underwriting 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**

THE HIGHLIGHTED INFORMATION IS NECESSARY TO INITIATE UNDERWRITING:

Proposed Insured Full Name:

_____

Date of Birth _____ Present Age _____

Sex _____ Height _____ Weight _____

State of Birth _____ Country of Birth _____

Social Security No. or ITIN _____

Face Amount $_____

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

****

Street Address _____

City, State, Zip _____

Home/Cell Phone _____

Work Phone _____

Plan Approved For:

☐ SIMPL Preferred ☐ SIMPL Standard. ☐ MWL

Premium Amount $_____

Amount paid with application $_____

Premium Mode:

☐ Monthly Bank Draft **OR** ☐ Direct Express Card

☐ Quarterly ☐ Semi-Annual

☐ Annual

OWNER of Policy (if other than Proposed Insured)

_____

Relationship _____

Social Security No._____

Address _____

Home/Cell Phone _____

Bank Information: Name of Financial Institution

_____

Routing #: _____

Account #:_____

Draft Date:_____

☐ Check here to draft first premium

Primary Beneficiary _____

Relationship _____

Home/Cell Phone _____

Contingent Beneficiary _____

Relationship _____

Home/Cell Phone _____

OR

DIRECT EXPRESS CARD: BENEFIT PAYMENT RESET DATE OF:

☐ 1st of month ☐ 3rd of month ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

Direct Express Card Acct. #_____ Exp. Date:_____

Name as it Appears on Card:_____

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? ☐ ☐
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 to have surgery or hospitalization, used oxygen due to a medical condition, been unable to care for yourself or been bedridden 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:

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. **(Attach another sheet if necessary):**

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 treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) ?..... ☐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

Signature of Agent: _____ ***(e-signed)*** Agent Number _____

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 oftime.

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.

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/THE CAPITOL 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/THE CAPITOL LIFE INSURANCE COMPANY, 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 INSURANCE COMPANY/THE CAPITOL LIFE INSURANCE COMPANY'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 LIBERTY BANKERS LIFE INSURANCE COMPANY/THE CAPITOL 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/THE CAPITOL 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/THE CAPITOL 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)