Bankers Fidelity®

Vantage Secure™ Application Package

Application Coversheet

Please use a separate coversheet for each application.

To: **Bankers Fidelity®** Underwriting Department

Fax Number: 1-404-926-4030

Email: bfluw@bflic.com

Date: _____

Producer Name: _____

Producer Phone Number: _____

Total # of pages being faxed/emailed (including this cover sheet): _____

Applicant Name: _____

Checklist:

- ❑ Application Pages (single sided)
- ❑ HIPAA Authorization
- ❑ Replacement Notice (if applicable)
- ❑ Accelerated Death Benefit Rider Disclosure* (if applicable)
- ❑ Bank Draft or Credit Card Authorization (if applicable)
- ❑ Copy of Voided Check for Bank Draft (if Draft elected)
- ❑ Copy of Initial Premium Check** (if applicable)

*The Accelerated Death Benefit Rider Disclosure, when required, must be submitted with the application; a copy is to be left behind with the applicant. This form is required in: AL, AR, IL, IN, KS, LA, MA, MI, MN, MS, MT, NE, NC, OH, OK, OR, PA, VA & WA.

* *Applications with an initial premium check may still be faxed or emailed in to speed up processing. After faxing or emailing the application, mail the original premium check with a copy of the first page of the application to:

Bankers Fidelity Life Insurance Company®

Attn: New Business

4370 Peachtree Road, NE

Atlanta, GA 30348-5185

Include a note with the initial premium check stating that the application was faxed or emailed in.

Comments/Details for Underwriting team:

_____

_____

_____

_____

Log into the Agent Portal to check application status.

If you have questions about this process, please contact the Underwriting Department at 1-866-458-7501.

Bankers Fidelity Life Insurance Company®

4370 Peachtree Road, NE, Atlanta, GA 30319
404-266-5600 or 800-241-1439

Underwriting Guidelines – Vantage Secure™

Level Benefit Whole Life Insurance Policy form ICC19 B 21901

Eligible Issue Ages

45 - 85

Base Benefit Options

Preferred and Standard: $1,000 increments

Age 45 - 75: $3,000-$50,000

Age 76 - 85: $3,000-$35,000

Medical Question on Application

Answer ALL questions completely, as directed.

Provide complete details for any "Yes" answer, where directed.

Note: Answering "No" to all of the medical questions on the application does not guarantee acceptance. The Underwriter reviews the applicant's entire medical history when making their decision.

Requested issue date should be at least 30 days after the application is submitted to allow sufficient time to underwrite the applicant.

The underwriting decision will be accepted/rejected based on the answers to the medical questions on the application. Once the application is accepted, underwriting will use information such as prescription drug check and telephone interviews to assess the application.

Disqualifying Medications

Refer to the Disqualifying Medications list to determine eligibility.

Underwriting & Eligibility Requirements

Simplified Issue Application

Build Chart

Prescription Drug Screen

Medical Claims Data

Telephone Interview

Build Chart

Refer to Build Chart (below) to determine if the applicant is eligible for coverage.

Whole Life Build Chart

Height	Decline if Under	Preferred Range	Standard Range	Decline if Over
4'2	< 65	65 - 125	126 - 146	> 146
4'3	< 67	67 - 130	131 - 152	> 152
4'4	< 70	70 - 135	136 - 158	> 158
4'5	< 72	72 - 140	141 - 164	> 164
4'6	< 75	75 - 146	147 - 171	> 171
4'7	< 78	78 - 151	152 - 177	> 177
4'8	< 81	81 - 157	158 - 183	> 183
4'9	< 84	84 - 162	163 - 190	> 190
4'10	< 87	87 - 168	169 - 197	> 197
4'11	< 90	90 - 174	175 - 204	> 204
5'0	< 93	93 - 180	181 - 210	> 210
5'1	< 96	96 - 186	187 - 218	> 218
5'2	< 99	99 - 192	193 - 225	> 225
5'3	< 102	102 - 198	199 - 232	> 232
5'4	< 105	105 - 204	205 - 239	> 239
5'5	< 109	109 - 211	212 - 247	> 247
5'6	< 112	112 - 217	218 - 255	> 255
5'7	< 115	115 - 224	225 - 262	> 262
5'8	< 119	119 - 231	232 - 270	> 270
5'9	< 122	122 - 238	239 - 278	> 278
5'10	< 126	126 - 244	245 - 286	> 286
5'11	< 130	130 - 251	252 - 294	> 294
6'0	< 133	133 - 259	260 - 303	> 303
6'1	< 137	137 - 266	267 - 311	> 311
6'2	< 141	141 - 273	274 - 320	> 320
6'3	< 145	145 - 281	282 - 329	> 329
6'4	< 148	148 - 288	289 - 337	> 337
6'5	< 152	152 - 296	297 - 346	> 346
6'6	< 156	156 - 303	304 - 355	> 355
6'7	< 160	160 - 311	312 - 364	> 364
6'8	< 164	164 - 319	320 - 374	> 374
6'9	< 168	168 - 327	328 - 383	> 383
6'10	< 173	173 - 335	336 - 393	> 393
6'11	< 177	177 - 343	344 - 402	> 402

BANKERS FIDELITY LIFE INSURANCE COMPANY®
4370 Peachtree Rd. NE, Atlanta, GA 30319

Agent/Producer Name	%	Agent/Producer #

APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Requested Effective Date: *cannot be 29th, 30th or 31st* Month ___ / Day ___ / Year ____	Deliver Policy to: ❑ Policyowner ❑ Agent/Producer

PROPOSED INSURED INFORMATION:

First Name	Middle Name/Initial	Last Name	
Date of Birth Month ___ / Day ___ / Year ____	Age as of Requested Effective Date:	Place (State) of Birth:	❑ Male ❑ Female
Social Security Number: ___-___-____			

CONTACT INFORMATION:

Residence Address (Street or Route & Box #)	Residence City	Residence State	Residence Zip Code
Mailing Address (if different from Residence Address)	Mailing City	Mailing State	Mailing Zip Code
Email Address	Send notices, including premium notices ❑ electronic via email ❑ U.S.P.S.		Residence County

Home Telephone # ( )	Mobile/Cell Telephone # ( )	Best # to call ❑ Home ❑ Mobile/Cell	Best time to call _____ ❑ AM ❑ PM

POLICYOWNER INFORMATION: ■ The Proposed Insured is the Policyowner, or:

Policyowner's Name		Relationship to Proposed Insured	
Policyowner's Mailing Address	Mailing City	Mailing State	Mailing Zip Code
Policyowner's Email Address		Send notices, including premium notices ❑ electronic via email ❑ U.S.P.S.	

Home Telephone # ( )	Mobile/Cell Telephone # ( )	Best # to call ❑ Home ❑ Mobile/Cell	Best time to call _____ ❑ AM ❑ PM

PAYOR: To whom should premium notices be sent? ■ Same address as Proposed Insured, or:

Payor Name	Relationship to Proposed Insured	Phone number ( )	
Address (Street or Route & Box#)	City	State	Zip Code
Payor's Email Address		Send notices, including premium notices ❑ electronic via email ❑ U.S.P.S.	

Application continued on next page

Application continued from previous page

PLAN/PREMIUM INFORMATION:

Underwriting Class: ❑ Preferred Non-Tobacco ❑ Standard

Life Insurance	Face Amount	Units Face Amt/1000	Annual Premium per Unit	Annual Premium for Face Amount
❑ Policy†	$_____	$_____	$_____	$_____
Optional Rider:				
❑ Waiver of Premium Rider	$_____	$_____	$_____	$_____

†Preferred and Standard automatically includes Accelerated Death Benefit.

Total Annual Premium for all benefits: $_____

If Semi-Annual, Quarterly or Monthly: multiply by modal factor**: **x**_____

Total Modal Premium: $_____

**Multiply number of Units by Annual Premium per Unit to determine Annual Premium for Face Amount requested.*

Add Recurring Modal Policy Fee**: +$_____

***Refer to rate sheet for modal factors and fees.*

Total Initial Premium Due: $_____

Initial Premium Payment

Method:
- ❑ Check/Money Order included
- ❑ Bank Draft*
- ❑ Credit Card*

*Bank Draft/Credit Card Charge Date:
- ❑ Upon Approval
- ❑ at Effective Date
- ❑ at Custom Date:

Initial Premium Draft/ Charge Date:

__ __ / __ __ / __ __
MO DAY YR

Recurring Premium Payment

Method:
- ❑ Check/Money Order
- ❑ Bank Draft*
- ❑ Credit Card*

Mode:
- ❑ Annual
- ❑ Semi-Annual
- ❑ Quarterly
- ❑ Monthly

*Requested Draft Day __ __
cannot be 29th, 30th or 31st

Cycle Billing Mode:
- ❑ 1st day of the Month ❑ 3rd Day of the Month
- ❑ 2nd Wednesday of the Month
- ❑ 3rd Wednesday of the Month
- ❑ 4th Wednesday of the Month

Billing Type:
- ❑ Individual
- ❑ Family*

**Complete Family Billing Form*

Automatic Premium Loan*:
❑ Yes ❑ No

*An automatic loan from the cash value of the policy will be made to pay overdue premiums. Interest charges are added.

BENEFICIARY INFORMATION: (If more than one beneficiary, % total must equal 100% for each category)

Name	%	Relationship to Insured	Social Security No. *(if known)*	Address *(Street, City, State & Zip)*	Telephone Number
Primary Beneficiary					
Primary Co-Beneficiary					
Contingent Beneficiary					
Contingent Co-Beneficiary					

Application continued on next page

Application continued from previous page

OTHER INSURANCE: Please answer the following questions regarding existing life coverage

1. a) Do you currently have any existing life insurance policies or annuity contracts in force, with us or any other company, or any applications for a life insurance policy or annuity contract pending with us or any other company? ..... ❑ Yes ❑ No

   b) Do you intend to replace or change any life insurance policies or annuity contracts, with us or any other company, with the life policy for which you are applying?..... ❑ Yes ❑ No

If "Yes" to either a) or b), provide the following information and complete the required Replacement Notice:

Name of Company:	Type (Name) of Policy:	Policy#:

AGREEMENT: Please read and sign the following Agreement

I agree to provide, to the best of my knowledge and ability, responses to the questions in this application that are complete, correct, and true.

Proposed Insured's signature _____ Date _____

PHYSICIAN INFORMATION:

2. Please provide the complete name, address and telephone number of your primary care physician:

Name	Telephone Number ( )
Address	

HEALTH INFORMATION: Please answer the following questions regarding your medical history.

3. What is your height and weight: ____ Feet | ____ Inches | ____ Lbs. (*Refer to the Build Chart)*

PART A: If the answer to any one of Questions 4 - 19 is "Yes", coverage is not available.

4. Have you been diagnosed, treated, tested positive for, or been given medical advice by a medical professional for AIDS or HIV, Alzheimer's, dementia, ALS, end-stage kidney disease, or required dialysis?..... ❑ Yes ❑ No

5. Have you been diagnosed, treated, tested positive for, or been given medical advice by a medical professional for having a terminal illness with a life expectancy of less than 12 months?..... ❑ Yes ❑ No

6. Have you plead guilty to or been convicted of a felony, or do you currently have any such charges pending against you?..... ❑ Yes ❑ No

In the past 12 months have you:

7. resided in a nursing home or assisted living facility, received home health care or hospice care, been hospitalized 3 or more times, or are you currently hospitalized?..... ❑ Yes ❑ No

8. required assistance or supervision with any activities of daily living, including bathing, continence, dressing, eating, toileting, or transferring (getting in and out of a bed or chair)?..... ❑ Yes ❑ No

Application continued on next page

Application continued from previous page

HEALTH INFORMATION (cont'd): Please answer the following questions regarding your medical history.

9. required the use of a wheelchair, motorized mobility aid, walker, or supplemental oxygen (not including supplemental oxygen used for sleep apnea)? ..... ❑ Yes ❑ No

10. been advised by a medical professional to have any surgeries or medical procedures that have not yet been completed? ..... ❑ Yes ❑ No

11. received or undergone medical testing for an organ or bone marrow transplant (excluding corneal)? ..... ❑ Yes ❑ No

12. been diagnosed, treated, tested positive for, or been given medical advice by a medical professional for diabetes requiring more than 50 units of insulin per day? ..... ❑ Yes ❑ No

Have you been diagnosed, treated, tested positive for, or been given medical advice by a medical professional for any of the following (including being prescribed and/or taking prescription medication):

13. systemic lupus, systemic scleroderma, Addison's Disease, or multiple sclerosis? ..... ❑ Yes ❑ No

14. chronic kidney disease, chronic renal insufficiency or failure, chronic liver disease, cirrhosis of the liver, chronic pancreatitis, or chronic hepatitis (excluding Type A)? ..... ❑ Yes ❑ No

15. COPD, chronic obstructive lung disease, emphysema, chronic bronchitis or any other chronic lung disease (excluding asthma), cystic fibrosis, or pulmonary fibrosis? ..... ❑ Yes ❑ No

16. cardiomyopathy or heart failure? ..... ❑ Yes ❑ No

17. Sickle Cell Anemia or any other chronic blood disorder (excluding non-sickle cell anemia)? ..... ❑ Yes ❑ No

18. bi-polar disorder, schizophrenia, or any other psychotic disorder? ..... ❑ Yes ❑ No

19. Huntington's Disease, Parkinson's Disease, or muscular dystrophy? ..... ❑ Yes ❑ No

PART B: If the answer to either Question 20 or 21 is "Yes", Preferred rates are not available and Standard rates may apply.

20. In the past 2 years, have you used any tobacco or tobacco products, including cigarettes, cigars, chewing tobacco, vape or e-cigarettes? ..... ❑ Yes ❑ No

21. Have you been diagnosed, treated, tested positive for, or been given medical advice by a medical professional for diabetes requiring less than 50 units of insulin? ..... ❑ Yes ❑ No

Question 22: If the date of diagnosis or the date of the last treatment is:

- **Over 5 years ago, Preferred rates may apply**
- **Over 3 years ago, but less than 5 years ago, Standard rates apply**
- **Within the past 3 years, or more than one "Yes" answer, coverage is not available**

In the past 5 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a medical professional for any of the following (including being prescribed and/or taking prescription medication):

22 a) any cancer (excluding basal/squamous cell of the skin)? ..... ❑ Yes ❑ No

If "Yes", provide month/year of diagnosis: ____ / ____
MM CCYY

Application continued on next page

Application continued from previous page

HEALTH INFORMATION (cont'd): Please answer the following questions regarding your medical history.

b) stroke or TIA/transient ischemic attack? ..... ❑ Yes ❑ No
If "Yes", provide month/year of diagnosis: ____ / ____
MM CCYY

c) heart attack, coronary or carotid artery disease, heart or circulatory surgery (excluding routine maintenance on a previously existing pacemaker)? ..... ❑ Yes ❑ No
If "Yes", provide month/year of diagnosis: ____ / ____
MM CCYY

d) diabetes with complications including diabetic coma, insulin shock, nephropathy, or retinopathy? ..... ❑ Yes ❑ No
If "Yes", provide month/year of diagnosis: ____ / ____
MM CCYY

e) drug or alcohol abuse? ..... ❑ Yes ❑ No
If "Yes", provide month/year of diagnosis: ____ / ____
MM CCYY

f) amputation due to disease? ..... ❑ Yes ❑ No
If "Yes", provide month/year of diagnosis: ____ / ____
MM CCYY

Application continued on next page

Application continued from previous page

23. I, the undersigned Proposed Insured, hereby apply to Bankers Fidelity Life Insurance Company® (hereinafter referred to as "the Company") for a Policy to be issued in reliance upon my written answers to the above questions. I represent that the answers given are, to the best of my knowledge and belief, complete, correct and true. I understand that the answers to the questions in this application and any medical information obtained and reviewed by the Company are the basis for any policy issued by the Company. I further understand that no answer will be considered to have been given by me unless it is stated in this application. No agent or sales representative is authorized to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I agree the Policy shall not be effective unless it has actually been issued, received by me and the first premium paid and honored by the financial institution upon which it is drawn on the first presentation, all during my lifetime and before any change in my health as stated herein.

To determine my eligibility for the coverage applied for herein, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health, to give to Bankers Fidelity Life Insurance Company or its reinsurer any such information. A photographic copy of this authorization shall be as valid as the original. This authorization is terminates the earlier of: 1) twelve (12) months from the date of this application; or 2) expiration of the time limit permitted by the state where the Policy is issued.

Federal law requires sufficient information to identify the parties to the purchase of a life insurance policy. Failure to provide such information when requested could result in the policy not being issued, issue being delayed, unprocessed transactions requests or policy termination.

Acknowledgement regarding electronic communications: Proper identification will be required for all electronic communications and transactions. Bankers Fidelity Life Insurance Company will be held harmless for any claim, liability, loss or cost, when we have used reasonable procedures to confirm communications and transactions are authorized and genuine and those procedures have been followed. The Proposed Owner hereby states s/he has access to the Internet for the purposes of accepting electronic delivery of such documents or transactions, which may involve, but is not limited to, premium payments, billing changes, beneficiary changes, or contact information. Bankers Fidelity Life Insurance Company will provide a digital method by which the Proposed Owner can provide a current Internet email address.

- ❑ By checking this box, I authorize Bankers Fidelity Life Insurance Company to provide the electronic communications described herein.
- ❑ By checking this box, I reject to receive the electronic communications described herein.

The undersigned Proposed Insured and Producer state that the Proposed Insured has read or had read to him or her the completed application and that the Proposed Insured realizes that any false statement or material misrepresentation in the application may result in loss of coverage under the Policy, subject to the "Incontestability" provision of the Policy. ANSWER ALL QUESTIONS COMPLETELY, CORRECTLY AND TRUTHFULLY.

WARNING: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at _____, on _____
(City and State) (Month/Day/Year)

X _____
Proposed Insured's signature.Read item 23 before signing

X _____
Writing Agent/Producer's signature

X _____
Proposed Owner's signature (if other than Proposed Insured)

X _____
Proposed Payor's signature (if other than Proposed Insured)

Application continued from previous page

WRITING AGENT/PRODUCER INFORMATION

Does the Proposed Insured currently have any existing life insurance policies or annuity contracts in force, with us or any other company, or any applications for a life insurance policy or annuity contract pending with us or any other company?..... ❑ Yes ❑ No

Does the Proposed Insured intend to replace or change any life insurance policies or annuity contracts, with us or any other company, with the life policy for which s/he is applying?..... ❑ Yes ❑ No

If "Yes" to either question, complete the required Replacement Notice.

I, the undersigned Agent/Producer, certify that: (1) I have personally interviewed the Proposed Insured; and (2) I have truly and accurately recorded the information supplied by the Proposed Insured.

Is the Proposed Insured related to you? ❑ Yes ❑ No If "Yes" explain relationship: ❑ Self ❑ _____

If "YES," the co-signature of an independent third party is required.

Dated at _____, on _____
(City and State) (Month/Day/Year)

X _____
Writing Agent/Producer's signature

X _____
Independent Third Party's co-signature; if required

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, NE, Atlanta, Georgia 30319

AUTHORIZATION TO RELEASE MEDICAL INFORMATION IN COMPLIANCE WITH HIPAA

In order for Bankers Fidelity Life Insurance Company® (or its affiliates or reinsurers) to evaluate my application for insurance, or if a policy is issued, to evaluate contestability or eligibility for payment of claims benefits and for the continuation or replacement of the policy, I hereby authorize any and all medical practitioners, physicians, nurses, pharmacists, hospitals, clinics, long-term care facilities, medical or medically-related facilities, laboratories, insurance companies and insurance support organizations (i.e.: the MIB Group), records custodians or anyone else with knowledge of me or my health to release any and all records and information within your possession, custody or control to Bankers Fidelity Life Insurance Company or its authorized representative.

Information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. Such records and information may include, but is not limited to, the following: alcohol and/or drug abuse treatment, psychiatric treatment (except psychotherapy notes), prescription drug information or STD or other communicable disease testing and treatment.

Bankers Fidelity Life Insurance Company cannot process an application for insurance without this signed Authorization. Furthermore, determination of eligibility for payment of claims benefits will be based upon information obtained in accordance with this authorization. Failure to authorize us to obtain information from all necessary providers may result in a delay of your claim due to lack of complete information.

I UNDERSTAND:

1. Health information about me provided to Bankers Fidelity Life Insurance Company is protected by federal privacy regulations and that Bankers Fidelity Life Insurance Company will only use and disclose such information as allowable by law. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal privacy regulations (i.e. an insurance regulatory or other government agency), the disclosed information may no longer be protected by those regulations.
2. I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance upon this authorization or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to Bankers Fidelity Life Insurance Company at the address above. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or business operations.
3. Bankers Fidelity may release information obtained through this Authorization to its reinsurers, the MIB or other insurance companies as allowable by law.
4. I am entitled to receive a copy of this authorization.
5. A photographic copy of this authorization is as valid as the original.
6. This authorization will expire 24 months from the date signed.

Dated at _____ on _____

_____	_____	_____
Patient's Signature	Patient's Printed Name	Patient's Date of Birth
_____	_____	_____
Patient's Resident Address	Patient's Social Security Number	Patient's Phone Number
_____	_____	_____
Personal Representative's Signature	Representative's Printed Name	Relationship to Patient*

*Describe Personal Representative's authority or relationship to Patient. If Power of Attorney, must provide copy of POA papers.

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, NE, Atlanta, Georgia 30319

Authorization for Release of Information to My Insurance Agent and/or Agency

In the event that my application is declined or my premiums are rated higher than I applied for, I authorize Bankers Fidelity Life Insurance Company® and their affiliated companies, or their authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Bankers Fidelity Life Insurance Company or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Bankers Fidelity Life Insurance Company may have taken based on this information.

The information will be used to help me with the insurance application process or to find other insurance coverage options. I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. I understand that I may refuse to sign this authorization. My refusal to sign it will not affect the the Company's decision to issue the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 60 days from the date I sign it.

I understand that I may revoke this authorization at any time, by written notice to:

Bankers Fidelity Life Insurance Company
ATTN: Underwriting
4370 Peachtree Rd NE
Atlanta, GA 30319

I realize that my right to revoke this authorization is limited to the extent that Bankers Fidelity Life Insurance Company has taken action in reliance on the authorization and does not affect any disclosures made prior to the receipt of the revocation of the authorization.

Proposed Insured's Signature	Printed Name	Date
Spouse's Signature (if applying for coverage)	Printed Name	Date

This form is only required in: AL, AR, IL, IN, KS, LA, MA, MI, MN, MS, MT, NE, NC, OH, OK, OR, PA, VA & WA.

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319
Local: (404) 266-5600; Toll Free: 1-800-241-1439

DISCLOSURE

The policy contains an Accelerated Death Benefit. This benefit provides for the payment of a portion of the Face Amount of the Policy should you become Terminally Ill.

You should be aware of the following:

1. Receiving accelerated benefits from life insurance policy may have tax consequences for you. We cannot give you advice about this. You should obtain advice from a tax professional before you decide to receive accelerated benefits from a life insurance policy.
2. If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others.
3. Receipt of accelerated benefits does not and is not intended to qualify as long-term care insurance.

Description of Accelerated Death Benefit:

The Accelerated Death Benefit will be paid to the Owner, or to any other person designated by the Owner upon due proof of the Insured's diagnosis as Terminally Ill with a life expectancy of twelve (12) months or less. Payment will be made in a single, lump sum payment. The Accelerated Death Benefit is payable one time only during the lifetime of the Rider. Once the Accelerated Death Benefit is paid, no further payments will be made.

The Accelerated Death Benefit is an amount equal to: 1) 50% of the Face Amount of the Policy; *MINUS 2*) 50% of any outstanding Indebtedness. Any outstanding Indebtedness will then be reduced by 50%.

Effect of payment of accelerated death benefits on premiums

Payment of the Accelerated Death Benefit will create a lien against the Death Benefit in an amount equal to the Accelerated Death Benefit paid under the Rider, thereby reducing the Death Benefits payable at the Insured's death. Access to the Cash Value of the Policy to exercise any non-forfeiture or surrender option is limited to the excess of the Cash Value over the sum of the lien against the Death Benefits plus any other outstanding Indebtedness. Payment of benefits under this Rider will not affect, change or reduce the premiums due for the Policy or any other optional benefit rider attached to the Policy.

PAYMENT OF BENEFITS UNDER THIS RIDER WILL CREATE A LIEN AGAINST THE DEATH BENEFT OF THE POLICY TO WHICH IT IS ATTACHED IN AN AMOUNT EQUAL TO THE ACCELERATED DEATH BENEFIT THAT WAS PAID UNDER THIS RIDER.

THE FACE AMOUNT PAYABLE AT THE INSUREDS DEATH WILL BE FIRST REDUCED BY THE AMOUNT OF ANY OUTSTANDING LIEN.

PAYMENT OF ACCELERATED DEATH BENEFITS WILL NOT AFFECT, CHANGE OR REDUCE THE PREMIUMS DUE FOR THE POLICY.

The undersigned Applicant and agent state that the Applicant has read, or had read to him or her, this Disclosure.

_____	_____	_____	_____
Applicant's signature	Date	Agent's signature	Date

Send to Company with completed application.

AUTHORIZATION TO HONOR RECURRING DRAFTS/WITHDRAWALS/CHARGES MADE BY AND PAYABLE TO BANKERS FIDELITY LIFE INSURANCE COMPANY®, ATLANTA, GA

I hereby authorize you to pay from and charge to my account listed below any draft, withdrawal or charge, including electronic transactions, made by and payable to Bankers Fidelity Life Insurance Company®, Atlanta, GA for the premiums due on my insurance policy, provided there are sufficient funds in said account to honor such draft, withdrawal or charge upon presentation. I agree that your rights in respect to each draft, withdrawal or charge shall be the same as if it were a check, withdrawal or charge made personally by me.

This authorization shall remain in effect until Bankers Fidelity Life Insurance Company® has received written notification from me revoking this authorization and in such manner as to afford reasonable opportunity to act upon it. I agree that if any draft, withdrawal or charge is dishonored or refused, you shall be under no liability whatsoever, even if such dishonor or refusal results in the forfeiture of insurance.

Complete appropriate section according to your payment method

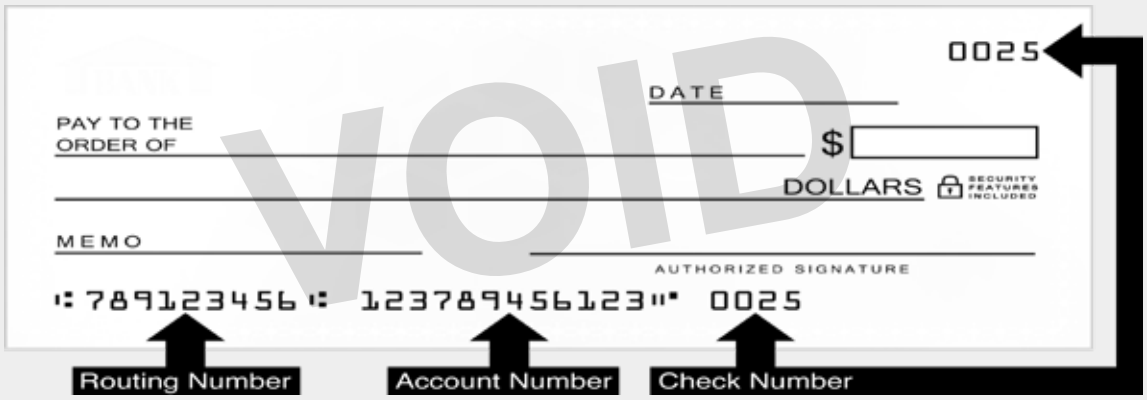
A. ❒ CREDIT CARD AUTHORIZATION

Type of Card: ❒ Mastercard ❒ Visa ❒ Discover ❒ American Express	Account Number:
Name of Card Holder as it appears on account	Expiration Date ____ / ____ Month Year
Signature of Card Holder	Date

B. ❒ CHECKING AUTHORIZATION ❒ SAVINGS ACCOUNT AUTHORIZATION

Name of Financial Institution:	
Routing/ABA Number:	Account Number:
Signature of Account Holder	Date

Attach a voided check. If the authorization is for a Savings Account, attach a deposit slip.



B 0129 MBD/CC (8-19)

COMPLETE FOR FAMILY BILLING/LIST BILL

Multiple policies can be paid on a single automatic draft from the same account or billed on a single billing notice. The policies can be on one person or multiple insureds, as long as they are billed on the same day. To set up Family Billing, we will need the following information:

NOTE: Family Billing/List Bill must have the same Payor for all policies listed.

Name of Payor:	Social Security Number
	___ — ___ — ____

Policy # (if existing policy)	Name of Primary Insured	Premium Amount
	Total Premium	**$**

Signature of Payor _____ Date_____

B 0129 FB/LB (2-11)

THE FOLLOWING PAGES SHOULD BE DETACHED AND LEFT WITH THE CLIENT.

NOTICE TO THE APPLICANT
PART ONE

Federal law requires that notice of investigation be given to persons applying for insurance.

In making this application for insurance to Bankers Fidelity Life Insurance Company®, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of the investigation. None of the information collected concerning the sexual orientation of the Proposed Insured will be used to determine his or her eligibility for insurance.

PART TWO

Information regarding your insurability will be treated as confidential. Bankers Fidelity Life Insurance Company® or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not for profit membership organization of 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, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Bankers Fidelity Life Insurance Company® or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

COMPLETE THIS RECEIPT ONLY IF INITIAL PREMIUM IS COLLECTED WITH THE APPLICATION.

Bankers Fidelity Life Insurance Company®

4370 Peachtree Road, N.E., P. O. Box 105185, Atlanta, Georgia 30348-5185

PREMIUM RECEIPT

Received from _____ the sum of $ _____ being payment on account of an application for insurance to the Bankers Fidelity Life Insurance Company®, which application bears the same date as this receipt. This receipt is for: _____ policy. Proposed insured: _____

The insurance applied for shall not take effect until a policy issued on the basis of the above mentioned application shall have been delivered to the proposed insured, and the full first premium paid, all during the lifetime and before any change in the insurability of the proposed insured as stated in the application. Otherwise, there shall be no liability on the part of the Company except to refund this payment upon surrender of this receipt.

Date _____ Agent _____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.
THIS RECEIPT IS NOT VALID IF INITIAL PREMIUM IS PAID BY CREDIT CARD.

DETACH AND LEAVE THIS PAGE WITH THE APPLICANT.

BANKERS FIDELITY LIFE INSURANCE COMPANY

4370 Peachtree Road, N.E., Atlanta, Georgia 30319
Local: (404) 266-5600; Toll Free: 1-800-241-1439

DISCLOSURE

The policy contains an Accelerated Death Benefit. This benefit provides for the payment of a portion of the Face Amount of the Policy should you become Terminally Ill.

You should be aware of the following:

1. Receiving accelerated benefits from life insurance policy may have tax consequences for you. We cannot give you advice about this. You should obtain advice from a tax professional before you decide to receive accelerated benefits from a life insurance policy.
2. If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others.
3. Receipt of accelerated benefits does not and is not intended to qualify as long-term care insurance.

Description of Accelerated Death Benefit:

The Accelerated Death Benefit will be paid to the Owner, or to any other person designated by the Owner upon due proof of the Insured's diagnosis as Terminally Ill with a life expectancy of twelve (12) months or less. Payment will be made in a single, lump sum payment. The Accelerated Death Benefit is payable one time only during the lifetime of the Rider. Once the Accelerated Death Benefit is paid, no further payments will be made.

The Accelerated Death Benefit is an amount equal to: 1) 50% of the Face Amount of the Policy; *MINUS 2*) 50% of any outstanding Indebtedness. Any outstanding Indebtedness will then be reduced by 50%.

Effect of payment of accelerated death benefits on premiums

Payment of the Accelerated Death Benefit will create a lien against the Death Benefit in an amount equal to the Accelerated Death Benefit paid under the Rider, thereby reducing the Death Benefits payable at the Insured's death. Access to the Cash Value of the Policy to exercise any non-forfeiture or surrender option is limited to the excess of the Cash Value over the sum of the lien against the Death Benefits plus any other outstanding Indebtedness. Payment of benefits under this Rider will not affect, change or reduce the premiums due for the Policy or any other optional benefit rider attached to the Policy.

PAYMENT OF BENEFITS UNDER THIS RIDER WILL CREATE A LIEN AGAINST THE DEATH BENEFT OF THE POLICY TO WHICH IT IS ATTACHED IN AN AMOUNT EQUAL TO THE ACCELERATED DEATH BENEFIT THAT WAS PAID UNDER THIS RIDER.

THE FACE AMOUNT PAYABLE AT THE INSUREDS DEATH WILL BE FIRST REDUCED BY THE AMOUNT OF ANY OUTSTANDING LIEN.

PAYMENT OF ACCELERATED DEATH BENEFITS WILL NOT AFFECT, CHANGE OR REDUCE THE PREMIUMS DUE FOR THE POLICY.

The undersigned Applicant and agent state that the Applicant has read, or had read to him or her, this Disclosure.

_____	_____	_____	_____
Applicant's signature	Date	Agent's signature	Date

An Example Numerical Demonstration of the Accelerated Death Benefit Calculation is shown on the reverse.

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Example Numerical Demonstration of Accelerated Death Benefit Calculation:

Based on a $10,000 Policy face amount and a current $500 outstanding Indebtedness:

[50]% Accelerated Death Benefit ($10,000 x .[50]) =	$5,000.00
Minus [50]% of the outstanding Indebtedness ($500 x .[50]) =	($250.00)
Total Proceeds	**$4,750.00**

Outstanding Indebtedness after payment of Accelerated Death Benefit = $250.00
Amount to be deducted from Death Benefits after payment of Accelerated Death Benefit=$5,000.00]

Premium required after payment of Accelerated Death Benefit - $[XX.XX]

Access to the Cash Value of the Policy after payment of the Accelerated Death Benefit is limited to the excess of the Cash Value over the sum of the lien against the Death Benefits plus any other outstanding Indebtedness.

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