Bankers Fidelity®

Vantage Care™ Application Package for Lump Sum Cancer Insurance Policy

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)
- ❑ 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)

* 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
PO Box 105185
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:

_____

_____

_____

_____

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, PO Box 105185, Atlanta, GA 30348-5185
404-266-5600 or 800-241-1439

Underwriting Guidelines - Vantage Care™

Lump Sum Cancer Insurance Policy Form Series B 21904

Eligible Issue Ages

18-99 (18-74 for Specified Disease Benefits)

Children are covered up to age 26

Medical Questions on Application

Answer ALL questions completely, as directed.

Base plan:	questions 3 – 5 are required.
Coverage over $30,000:	question 6 is required.
Heart-Stroke Benefit Rider:	questions 7 – 8 are required.
Specified Disease Benefit Rider:	questions 9 – 10 are required.

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. All policies will be issued as applied for or declined.

Underwriting & Eligibility Requirements

Simplified Issue Application

Build Chart

Prescription Drug Screen

Telephone Interview

Build Chart			
Feet	Inches	Decline if Under	Decline if Over
4	2	61	157
4	3	63	163
4	4	66	170
4	5	68	176
4	6	71	183
4	7	74	190
4	8	76	197
4	9	79	204
4	10	82	211
4	11	85	218
5	0	88	226
5	1	90	233
5	2	93	241
5	3	96	249
5	4	100	257
5	5	103	265
5	6	106	273
5	7	109	281
5	8	112	290
5	9	116	298
5	10	119	307
5	11	122	316
6	0	126	325
6	1	129	334
6	2	133	343
6	3	137	353
6	4	140	362
6	5	144	372
6	6	148	381
6	7	151	391
6	8	155	401
6	9	159	411
6	10	163	421
6	11	167	432

Premium Calculation

Carcinoma In Situ: ❑ 25% or ❑ 100%

	Annual Premium
Cancer Benefit	$ _____
x Number of Units (5 – 75)	_____
= Cancer Benefit Annual Premium	**$** (1)
Optional Heart-Stroke Benefit	$ _____
x Number of Units (5 – 75; cannot exceed Cancer Benefit)	_____
= Optional Heart-Stroke Benefit Annual Premium	**$** (2)
Benefit Builder Rider	$ _____
x Number of Units (1 – 20)	_____
= Benefit Builder Rider Annual Premium	**$** (3)
Specified Disease Benefit Rider	$ _____
x Number of Units (5 – 75)	_____
= Specified Disease Benefit Rider Annual Premium	**$** (4)
Additional Occurrence Benefit Rider	$ _____
x Number of Units (must equal base benefit units)	_____
= Additional Occurrence Benefit Rider Annual Premium	**$** (5)
Cancer Hospitalization Rider	$ _____
x Number of Units (1 – 10)	_____
= Cancer Hospitalization Rider Annual Premium	**$** (6)
Cancer Radiation and Chemotherapy Benefit Rider	$ _____
x Number of Units (1 – 10)	_____
= Cancer Radiation and Chemotherapy Benefit Rider Annual Premium	**$** (7)
Second Opinion and Travel Benefit Rider	$ _____
x Number of Units	1
= Second Opinion and Travel Benefit Rider Annual Premium	**$** (8)
Skin Cancer Benefit Rider	$ _____
x Number of Units (1 – 4)	_____
= Skin Cancer Benefit Rider Annual Premium	**$** (9)
Wellness Benefit Rider	$ _____
= Wellness Benefit Rider Annual Premium	**$** (10)
Total Annual Premium (1+2+3+4+5+6+7+8+9+10)	$ _____
x Modal Factor	_____
= Total Modal Premium	$

For premium modes other than Annual, multiply the Total Annual Premium by the modal factor.

Modal Factors:

Semi-Annual:	0.50	Monthly Bank Draft:	0.08333
Quarterly:	0.25	Monthly Credit Card:	0.08583

The premium rates expressed in this worksheet are intended to be as accurate as possible; however, they do not represent a binding premium offer and the actual premium for the policy as applied for may be different. Errors made in the recording of individual benefit premiums, the number of units desired, a miscalculation of any of the items, or variances in the application of rounding methods, may cause the premiums on any issued policy to be different from those presented herein.

BANKERS FIDELITY LIFE INSURANCE COMPANY®
4370 Peachtree Rd. NE, PO Box 105185, Atlanta, GA 30348-5185

Agent/Producer Name	%	Agent/Producer #

Application for Cancer Insurance

THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Requested Effective Date: *cannot be 29th, 30th or 31st*	Month / Day / Year	Deliver Policy to: ❑ Insured (USPS Mail) ❑ Agent/Producer (Electronic)

PROPOSED INSURED(S) INFORMATION:

Name: First, Middle Initial, Last	Gender	Date of Birth Month/Day/Year	Social Security Number *(if known)*	Height Feet | Inches	Weight Lbs.
Primary Proposed Insured					
Spouse/Domestic Partner					
Dependent Child 1					
Dependent Child 2					
Dependent Child 3					
Dependent Child 4					
Dependent Child 5					

PRIMARY PROPOSED INSURED 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:	I agree to electronic delivery of notices, including premium notices, unless this box is checked: ❑ send U.S.P.S.		Residence County
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:	I agree to electronic delivery of notices, including premium notices, unless this box is checked: ❑ send U.S.P.S.		

Application continued on next page

PLAN/PREMIUM INFORMATION:

Rate Class:
❑ Non-Tobacco*
❑ Tobacco

*In the past 2 years, has the Proposed Insured or Spouse (if applying) used any type of tobacco products or any nicotine-related products, including e-cigarettes or vaping?.....❑ Yes ❑ No
If "Yes", Tobacco rates apply.

Benefit Options: **Modal Premium***

❑ **Cancer Policy** Carcinoma In Situ benefit payable at: ❑100% ❑ 25% $ _____
Requested Benefit Amount: $_____ ($1,000/unit; min. $5,000; max. $75,000)

❑ **Optional Heart-Stroke Benefit** $ _____
Requested Benefit Amount: $_____ ($1,000/unit; min. $5,000; max. $75,000)

Optional Benefit Riders – choose one or more:

❑ **Additional Occurrence Benefit Rider** *(if Heart-Stroke is included in base plan, the Cancer and Heart-Stroke benefit amounts must be equal for this Rider to be included)* $ _____

❑ **Benefit Builder Rider** $ _____
Requested Benefit Amount: $_____ ($100/unit; min. $100; max. $2,000)

❑ **Specified Disease Benefit Rider** $ _____
Requested Benefit Amount: $_____ ($1,000/unit; min. $5,000; max. $75,000)

❑ **Cancer Hospitalization Rider** $ _____
Requested Benefit Amount: $_____ ($100/unit; min. $100; max. $1,000)

❑ **Cancer Radiation and Chemotherapy Rider:** Number of Units : _____ (min 1; max 10) $ _____

❑ **Wellness Rider:** ❑ $25 ❑ $50 ❑ $75 ❑ $100 $ _____

❑ **Cancer Second Opinion and Travel Rider** $ _____

❑ **Skin Cancer Rider:** $ _____
Requested Benefit Amount: $_____ ($250/unit; min. $250; max. $1,000)

Refer to rate sheet for modal premiums and fees.* **Total Initial Premium Due: $ _____

Initial Premium Payment:
❑ Check/Money Order included
❑ Charge Credit Card*
❑ Draft Upon Approval
❑ Draft Initial Premium*

*Initial Premium Draft/Charge Date:
__ __ / __ __ / __ __
MO DAY YR

Recurring Premium Mode:
❑ Annual
❑ Semi-Annual
❑ Quarterly
❑ Monthly Bank Draft*
❑ Monthly Credit Card* __ __
*Requested Draft Day
cannot be 29th, 30th or 31st

Billing Type: ❑ Individual
❑ Family*
**Complete Family Billing Form*

BENEFICIARY INFORMATION:

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

Application continued on next page

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

1. a) Does any Proposed Insured intend to replace any existing or pending supplemental health insurance with the policy being applied for herein? ..... ❑ Yes ❑ No
If "Yes" complete a Replacement Notice, if required by statute or regulation.

b) Is any Proposed Insured currently covered by any Title XIX program (Medicaid or similar program by any other name)? ..... ❑ Yes ❑ No
If "Yes", coverage is not available for that/those person(s).

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.

Coverage is not available for any Proposed Insured for whom the answer to any part of Questions 3 – 5 is "Yes".

3. Has any Proposed Insured been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? ..... ❑ Yes ❑ No

4. Within the past two (2) years, has any Proposed Insured been medically advised to undergo treatment, testing, or had tests performed where the results are pending, have not been received, were abnormal, or were inconclusive for which a member of the medical profession has not ruled out cancer? ..... ❑ Yes ❑ No

5. Within the past five (5) years, has any Proposed Insured been medically diagnosed with, received treatment* for, or consulted with a medical professional for any form of cancer, including but not limited to leukemia, Hodgkin's disease, lymphoma, melanoma, sarcoma, myeloma or carcinoma in situ (not including basal or squamous cell skin cancer)? ..... ❑ Yes ❑ No
**Treatment includes any ongoing immunotherapy, hormonal therapy, or chemotherapy meant to decrease the risk of recurrence of cancer, carcinoma in situ, malignant melanoma, or any other malignancy.*

Answer Question 6 if applying for coverage above $30,000.00.

Coverage above $30,000.00 is not available if the answer to Question 6 is "Yes".

6. Within the past five (5) years, has any Proposed Insured been medically diagnosed with or treated for, been medically advised to have treatment, prescribed medications or consulted with a member of the medical profession for any of the following conditions listed below? ..... ❑ Yes ❑ No

- alcoholism
- alcohol abuse
- cystic fibrosis
- Down's syndrome
- drug abuse
- drug addiction
- Duchenne muscular dystrophy
- Fragile X syndrome (FXS or Martin-Bell syndrome)
- Hemophilia
- Huntington's disease
- Sickle cell anemia
- Thalassemia

Application continued on next page

Answer Questions 7 and 8 if applying for the optional Heart-Stroke Benefit. **The Heart-Stroke Benefit is not available if the answer to Question 7 or 8 is "Yes".**	7. Within the past five (5) years, has any Proposed Insured been medically diagnosed with or treated for, been medically advised to have treatment, prescribed medications or consulted with a member of the medical profession for any of the following conditions listed below? ..... ❑ Yes ❑ No • a heart attack, stroke or Transient Ischemic Attack (TIA) • atrial fibrillation, cardiomyopathy, or heart failure • any heart or circulatory surgery (excluding maintenance on a previously installed pacemaker) • complications of diabetes or insulin-dependent diabetes, including but not limited to nephropathy, neuropathy or retinopathy (excluding gestational) • a disease or disorder of the kidneys (excluding kidney stones) or kidney disease requiring dialysis
	8. Does any Proposed Insured have either high blood pressure or high cholesterol which requires the use of four or more medications to control? ..... ❑ Yes ❑ No
Answer Questions 9 and 10 if applying for the optional Specified Disease Benefit Rider. **The Specified Disease Benefit Rider is not available if the answer to Question 9 or 10 is "Yes".**	9. Has any Proposed Insured ever received an organ transplant or been advised of the need for an organ transplant? ..... ❑ Yes ❑ No
	10. Within the past five (5) years, has any Proposed Insured been medically diagnosed with or treated for, been medically advised to have treatment, prescribed medications or consulted with a member of the medical profession for any of the following conditions listed below? ..... ❑ Yes ❑ No • emphysema, chronic obstructive pulmonary disease (COPD), or any other disease or disorder of the lungs (excluding asthma) • hepatitis (excluding A), cirrhosis, or any other disease or disorder of the liver • alcohol or drug abuse or dependency • any disorder of the nervous system including Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's disease) • Alzheimer's disease, dementia, or cognitive impairment • glaucoma, retinitis pigmentosa, macular degeneration, optic neuritis, or blindness lasting more than thirty (30) days • loss of muscle function in any part of the body • traumatic brain injury or periods of prolonged unconsciousness that were not medically induced • any disease or disorder of the kidneys (excluding kidney stones), any kidney disease requiring dialysis, or kidney/renal failure or insufficiency

Provide details for "Yes" responses to Questions 3 – 10, including applicant name, condition, date of diagnosis and any types of treatment received or surgeries performed. Use additional sheet if necessary.

Application continued on next page

11. 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; and, that 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, the undersigned Proposed Insured, agree the Policy shall not be effective unless it has actually been issued by the Company, 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 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.

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 Primary Insured hereby states s/he has access to the Internet for the purposes of accepting electronic delivery of such documents. Bankers Fidelity Life Insurance Company will provide a digital method by which the Proposed Primary Insured can provide a current Internet email address.

The undersigned Proposed Insured and Writing Agent/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 "Time Limit on Certain Defenses" provision of the Policy.

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.

NOTICE OF 30-DAY WAITING PERIOD: The Policy contains a 30-day Waiting Period which, for each Proposed Insured, begins on the date the Policy becomes effective for that person. No benefits are payable for any Loss that begins during the first thirty (30) days after the Policy becomes effective for each Proposed Insured.

The Proposed Insured acknowledges receipt of the outline of coverage for the policy applied for herein and the *Guide to Health Insurance for People with Medicare* (if any Proposed Insured is age 65 or older).

Dated at _____, on _____ X _____

(City and State) (Month/Day/Year) Proposed Insured's signature. Read item 11 before signing

X _____ X _____

Writing Agent/Producer's signature Spouse's signature (if applying for coverage)

X _____

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

WRITING PRODUCER INFORMATION

Does any Proposed Insured intend to replace or change any supplemental health policies with the cancer policy for which s/he is applying? ..... ❑ Yes ❑ No
If "Yes", complete the Replacement Notice, if required.

I, the undersigned Agent/Producer, certify that: (1) I have personally interviewed the Proposed Insured(s) (excluding minor children); (2) I have asked every question to each Proposed Insured exactly as written, and (3) I have truly and accurately recorded the information supplied by the Proposed Insured(s). I certify I have given the Proposed Insured an outline of coverage for the policy applied for and a *Guide to Health Insurance for People with Medicare*, if any Proposed Insured is age 65 or older.

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

Dated at _____,on _____ X _____
(City and State) (Month/Day/Year) Writing Agent's/Producer's signature

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

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

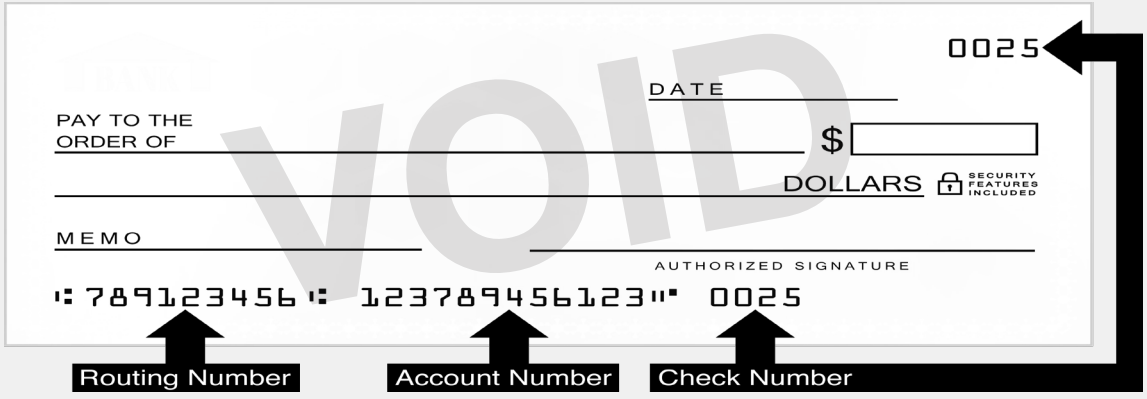
A. ❒ CREDIT CARD AUTHORIZATION

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)

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.