APPLICATION FOR INSURANCE PART II **LIBERTY LIFE INSURANCE COMPANY, Greenville, SC**

Name _____ Date of Birth ___/___/___ Social Security No. _____
FIRST MI LAST MM / DD / YYYY

Give full details to Yes answers, including specific diagnoses, results, dates of onset and recovery, and names and addresses of all healthcare professionals and medical facilities. ***(Attach additional sheets if necessary.)***

		Details to Yes Answers
1. In the past ten (10) years, have you been tested for; received any treatment, medical advice, or consultation for; been diagnosed with; or required follow-up for:		
a. high blood pressure, chest pain, irregular heart rhythm, palpitations, heart murmur, heart attack, heart failure, angina, phlebitis, peripheral vascular disease, or any other disease or disorder of the heart or blood vessels?	O Yes O No	
b. epilepsy, seizures, tremors, dizziness, headaches, fainting spells, stroke, paralysis, head injury, memory loss, Alzheimer's disease, dementia, or any other disease or disorder of the brain or nervous system?	O Yes O No	
c. diabetes or any disease or disorder of the pituitary, thyroid, parathyroid, or adrenal glands?	O Yes O No	
d. leukemia, lymphoma, tumor or any other form of cancer or malignancy?	O Yes O No	
e. anemia, polycythemia, clotting or platelet disorder, or any other disease or disorder of the blood or spleen?	O Yes O No	
f. cyst, polyp, lump, or other growth, or any disease or disorder of the breast, skin, or lymph nodes?	O Yes O No	
g. asthma, bronchitis, emphysema, COPD, pneumonia, sarcoidosis, sleep apnea, tuberculosis, shortness of breath, persistent hoarseness or cough, coughing up blood, or any other disease or disorder of the lung or respiratory system?	O Yes O No	
h. hepatitis, ulcer, blood in stool, colitis, or any other disease or disorder of the stomach, esophagus, liver, pancreas, gallbladder, intestines, colon, or rectum?	O Yes O No	
i. protein, blood, or sugar in the urine, or any disease or disorder of the kidney, bladder, prostate, or reproductive system?	O Yes O No	
j. arthritis, lupus, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the muscles, connective tissues, or bones?	O Yes O No	
k. anxiety, depression, schizophrenia, bipolar disorder, suicide attempt(s), or any other mental or nervous disorder?	O Yes O No	
l. any disease or disorder of the eyes, ears, nose, or throat?	O Yes O No	
2. In the past year, have you used any form of tobacco or nicotine-based products? (If Yes, indicate types, date last used, and quantity per day.)	O Yes O No	
3. Have you been diagnosed as having AIDS, AIDS Related Complex (ARC), or any other disorder of your immune system, or had a positive HIV test?	O Yes O No	
4. Have you lost more than ten (10) pounds in the last year? (If Yes, give reason.)	O Yes O No	
5. To the best of your knowledge, are you now pregnant? (If Yes, provide number of months.)	O Yes O No	

6. Are you currently taking any medications (prescription, injection, over the counter) or herbal remedies? (If Yes, list the medications/remedyies with dosages in space provided below.) O Yes O No

MEDICATION/ HERBAL REMEDY	DOSAGE	CONDITION	CURRENTLY TAKING?	MEDICATION/ HERBAL REMEDY	DOSAGE	CONDITION	CURRENTLY TAKING?
			O Yes O No				O Yes O No
			O Yes O No				O Yes O No
			O Yes O No				O Yes O No
			O Yes O No				O Yes O No
			O Yes O No				O Yes O No
			O Yes O No				O Yes O No

APPLICATION FOR INSURANCE PART II **LIBERTY LIFE INSURANCE COMPANY, Greenville, SC**

Name _____ Date of Birth ___/___/___ Social Security No. _____
FIRST MI LAST MM/DD/YYYY

Give full details to Yes answers, including specific diagnoses, results, dates of onset and recovery, and names and addresses of all healthcare professionals and medical facilities. ***(Attach additional sheets if necessary.)***

		Details to Yes Answers
7. Do you consume alcoholic beverages? (If Yes, provide amount and frequency.)	O Yes O No	
8. Have you:		
a. ever used heroin, cocaine (including crack), LSD, PCP, amphetamines, barbiturates, any derivative of these drugs, or any other controlled substance except as prescribed to you by a healthcare professional licensed to prescribe controlled substances?	O Yes O No	
b. ever been arrested for, convicted of, or pled guilty or no contest to drug possession or distribution?	O Yes O No	
c. sought counseling for suicide prevention or for thoughts about suicide?	O Yes O No	
d. received or been advised by a healthcare professional to receive treatment or counseling for alcohol or drug use?	O Yes O No	
e. been advised by a healthcare professional to reduce or stop alcohol or drug use?	O Yes O No	
f. been a member of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?	O Yes O No	
9. Have you requested or received any Worker's Compensation, Social Security, sickness or disability benefits or compensation?	O Yes O No	
10. During the past five (5) years, have you:		
a. been advised to have any diagnostic test, surgery, or hospitalization which has not been completed?	O Yes O No	
b. had surgery, or been admitted to any medical facility for any condition not disclosed in the preceding questions?	O Yes O No	
c. consulted, been examined, or been treated by any healthcare professional for any condition not disclosed in the preceding questions?	O Yes O No	
11. Have your natural parents, brother(s) or sister(s) been diagnosed with or died from any of the following conditions prior to age 60? (Check ✓all that apply.)	O Yes O No	
O cancer O diabetes O stroke O high blood pressure O heart attack, heart failure, or any other cardiovascular disease (If Yes, please provide full details.)		

RELATIVE	CONDITION(S) SUFFERED	AGE AT ONSET	AGE AT DEATH

12. Do you have a personal physician? O Yes O No

a. Name _____ d. Telephone # ( ) _____

b. Street _____ e. Date and reason for last consultation _____

c. City/State/Zip Code _____ _____

I represent that the statements and answers given in this Application Part II are true, complete, and correctly recorded.

Signed at: _____
CITY STATE

✗ _____ _____ ✗ _____ _____
SIGNATURE OF THE PROPOSED INSURED DATE SIGNATURE OF THE EXAMINER, BROKER OR WITNESS DATE

RBC Insurance

NOTICE AND CONSENT FOR HIV RELATED TESTING

Liberty Life Insurance Company PO Box 789 Greenville, South Carolina 29602-0789

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations.
Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result.
The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test. Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy charges may be necessary.

Confidentiality of Test Results.
All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover the results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result.
If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver the information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Physician's Name and Address:_____

In the event the test is positive and you are denied coverage because of the fact that you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information. If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent.
I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ Date:_____
Name of Proposed Insured

_____
Signature of Proposed Insured or Legal Guardian, if applicable

Authorization for Release of Health Information to Liberty Life Insurance Company ("Company")

_____ _____/_____/_____

Name of Proposed Insured (Please Print) Date of birth

I, the undersigned person, authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager, or other healthcare provider that has provided payment, treatment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Company, its agents, employees, representatives and reinsurers. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I also authorize any insurance company, the Medical Information Bureau, or other organization, institution, or person ("Other Persons") that has any records or knowledge of me or my health, to give to the Company, its agents, its employees, its representatives and its reinsurers any such information. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers or with Other Persons to restrict my protected health information and I instruct My Providers and Other Persons to release and disclose my entire medical record and other records or knowledge of me or my health without restriction.

This protected health information is to be disclosed under this Authorization so that the Company may: (1) underwrite my application for coverage, make risk rating determinations and make policy issuance determinations; (2) obtain reinsurance; and (3) conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing at any time by sending a written request for revocation to Liberty Life Insurance Company, PO Box 19078, Greenville, SC 29602-9078. I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I also understand that if I refuse to sign this Authorization, the Company may not be able to process my application. I understand that I have a right to receive a copy of this Authorization.

_____ _____

Proposed Insured or Personal Representative Date

_____

Description of Personal Representative's authority or relationship to Proposed Insured.