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 sheet[s] if necessary.)***

Question	Answer	**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; required follow-up for; or had any known indication of:		
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?	○ Yes ○ 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?	○ Yes ○ No	
c. diabetes or any disease or disorder of the pituitary, thyroid, parathyroid, or adrenal glands?	○ Yes ○ No	
d. leukemia, lymphoma, tumor or any other form of cancer or malignancy?	○ Yes ○ No	
e. anemia, polycythemia, clotting or platelet disorder, or any other disease or disorder of the blood or spleen?	○ Yes ○ No	
f. cyst, polyp, lump, or other growth, or any disease or disorder of the breast, skin, or lymph nodes?	○ Yes ○ 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?	○ Yes ○ 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?	○ Yes ○ No	
i. protein, blood, or sugar in the urine, or any disease or disorder of the kidney, bladder, prostate, or reproductive system?	○ Yes ○ No	
j. arthritis, lupus, chronic fatigue syndrome, fibromyalgia, or any other disease or disorder of the muscles, connective tissues, or bones?	○ Yes ○ No	
k. anxiety, depression, schizophrenia, bipolar disorder, or any other mental or nervous disorder?	○ Yes ○ No	
l. any disease or disorder of the eyes, ears, nose, or throat?	○ Yes ○ No	
2. In the past year, have you used any form of tobacco or nicotine-based products? (If Yes, indicate type[s], date last used, and quantity per day.)	○ Yes ○ 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?	○ Yes ○ No	
4. Have you lost more than ten (10) pounds in the last year? (If Yes, give reason.)	○ Yes ○ No	
5. To the best of your knowledge, are you now pregnant? (If Yes, provide number of months.)	○ Yes ○ No	

6. a. Are you currently taking any medications (prescription, injection, over the counter) or herbal remedies? (If Yes, list the medication[s]/remedy[ies] with dosage[s] in space provided below.) ○ Yes ○ No

b. In the past two (2) years, have you been advised to take any medications (prescription, injection, or over the counter) other than already disclosed in question 6.a.? (If Yes, list the medication[s] with dosage[s], and the name of the condition for which you are taking this medication.) ○ Yes ○ No

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

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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 sheet[s] if necessary.)***

Question		**Details to Yes Answers**
7. Do you consume alcoholic beverages? (If Yes, provide amount and frequency.)	○ Yes ○ 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?	○ Yes ○ No	
b. ever been arrested for, convicted of, or pleaded "guilty" or "no contest" to drug possession or distribution?	○ Yes ○ No	
c. attempted suicide or sought counseling for suicide prevention or for thoughts about suicide?	○ Yes ○ No	
d. received or been advised by a healthcare professional to receive treatment or counseling for alcohol or drug use?	○ Yes ○ No	
e. been advised by a healthcare professional to reduce or stop alcohol or drug use?	○ Yes ○ No	
f. been a member of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)?	○ Yes ○ No	
9. Have you requested or received any Worker's Compensation, Social Security, sickness or disability benefits or compensation?	○ Yes ○ 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?	○ Yes ○ No	
b. had surgery, or been admitted to any medical facility for any condition not disclosed in the preceding questions?	○ Yes ○ No	
c. consulted, been examined, or been treated by any healthcare professional for any condition not disclosed in the preceding questions?	○ Yes ○ 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 3all that apply.) ○ cancer ○ diabetes ○ stroke ○ high blood pressure ○ heart attack, heart failure, or any other cardiovascular disease (If Yes, please provide full details.)	○ Yes ○ No	

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

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

a. Name ______________________________
b. Street ______________________________
c. City/State/Zip Code ______________________________
d. Telephone # (   ) ______________________________
e. Date and reason for last consultation ______________________________

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

Authorization for Release of Health Information
To Liberty Life Insurance Company ("Company")
(This authorization complies with the HIPAA Privacy Rule)

____
Name of Proposed Insured (Please Print)

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, pharmacy, medical facility, 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 protected health information 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 acknowledge that I have received a copy of this Authorization.

______________________________________	______________________________________
Proposed Insured or Personal Representative	Date

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

NOTICE AND AUTHORIZATION FOR HIV ANTIBODY TESTING

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

In connection with your insurance application, your blood or other bodily fluid specimen will be tested for the presence of the AIDS virus (HIV) antibody. Because of the serious nature of HIV-related illnesses, being tested may cause anxiety. You may want to obtain counseling before undergoing this test. Your doctor or local Red Cross may provide pre-test counseling. You should be aware that a positive test result will result in the denial of your insurance application.

Information About AIDS.
AIDS is a condition caused by the human immunodeficiency virus (HIV). In some individuals, the virus reduces the body's normal defense mechanisms against certain diseases or infections. The symptoms of AIDS may include the following, although other causes of these symptoms are more likely: unexplained weight loss; persistent night sweats, cough, shortness of breath, diarrhea and white spots evidencing fungal infection; fever and swollen lymph nodes lasting more than one month; and raised purple spots on or under the skin or on mucous membranes. Please read the brochure accompanying this form for more information about HIV, how it is spread, and how to prevent exposure.

HIV Antibody Test.
The HIV antibody test is actually a series of tests designed to detect the presence of antibodies to the AIDS virus rather than detect the virus itself. Your blood or other bodily fluid specimen will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat ELISA test is also positive, your blood or other bodily fluid specimen will then be subjected to another, more specific technique called the Western blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA tests and a Western blot test. While positive HIV antibody test results do not mean that you have AIDS, they do indicate that you have been infected with HIV. Infected people are at an increased risk of developing AIDS or AIDS-related conditions. If your test result is positive, depending on State law, it will either be sent to the doctor you designate on this form or mailed directly to you. It is strongly recommended that you consult a physician or obtain counseling to learn more about the meaning of a positive test result.

Confidentiality.
All test results will be treated confidentially. The laboratory conducting the test will report the results to Liberty Life Insurance Company. Liberty Life may disclose test results to others such as its affiliates, reinsurers, employees, contractors or attorneys who need AIDS-related information for underwriting, claims or another necessary business purpose in connection with your insurance transaction. If you test positive, State law may also require Liberty Life to notify your local department of health. If the final HIV test result is other than normal, Liberty Life will report to the Medical Information Bureau (MIB, Inc.), a generic code that signifies only a non-specific test abnormality. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

Authorization.
I have read and understand this Notice and Authorization of HIV Antibody Testing and acknowledge receiving and reading the Red Cross "Testing For HIV Infection" brochure (or its successor). This authorization is valid for 90 days from the date of my signature below. I authorize the drawing and testing of my blood, urine, or oral fluid for HIV antibodies and the disclosure of the test results as stated on this form.

If permitted by State law, I wish Liberty Life to release a positive test result to [check one]:

☐ Myself only

☐ My physician [State law may **require** Liberty Life to send the result to your physician. Therefore, please provide the name and address of your personal physician below even if you do not choose this option.]

☐ Both myself and my physician

____
Physician's Name and Address

____
Name of Proposed Insured

____   ____________________
Signature of Proposed Insured or Legal Guardian, if applicable   Date