Vantage Flex *Plus*™ Hospital Indemnity 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 Writing Number: _____

Producer Phone Number: _____

Producer Fax Number: _____

Producer email address: _____

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

Applicant Name: _____

Plan Type: _____

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 applicable)
- ❑ 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: _____

_____

_____

_____

_____

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, N.E., P. O. Box 105185, Atlanta, GA 30348-5185
404-266-5600 or 800-241-1439

Vantage Flex *Plus*™ Underwriting Guidelines

Hospital Indemnity Policy Form Series HI21BFLIC

Height and Weight Table

Refer to the Height and Weight Table (at right) to determine if the applicant is eligible for coverage.

Build Chart

Height	Decline if Under	Preferred Range	Decline if Over
4'2	< 65	65 - 125	> 125
4'3	< 67	67 - 130	> 130
4'4	< 70	70 - 135	> 135
4'5	< 72	72 - 140	> 140
4'6	< 75	75 - 146	> 146
4'7	< 78	78 - 151	> 151
4'8	< 81	81 - 157	> 157
4'9	< 84	84 - 162	> 162
4'10	< 87	87 - 168	> 168
4'11	< 90	90 - 174	> 174
5'0	< 93	93 - 180	> 180
5'1	< 96	96 - 186	> 186
5'2	< 99	99 - 192	> 192
5'3	< 102	102 - 198	> 198
5'4	< 105	105 - 204	> 204
5'5	< 109	109 - 211	> 211
5'6	< 112	112 - 217	> 217
5'7	< 115	115 - 224	> 224
5'8	< 119	119 - 231	> 231
5'9	< 122	122 - 238	> 238
5'10	< 126	126 - 244	> 244
5'11	< 130	130 - 251	> 251
6'0	< 133	133 - 259	> 259
6'1	< 137	137 - 266	> 266
6'2	< 141	141 - 273	> 273
6'3	< 145	145 - 281	> 281
6'4	< 148	148 - 288	> 288
6'5	< 152	152 - 296	> 296
6'6	< 156	156 - 303	> 303
6'7	< 160	160 - 311	> 311
6'8	< 164	164 - 319	> 319
6'9	< 168	168 - 327	> 327
6'10	< 173	173 - 335	> 335
6'11	< 177	177 - 343	> 343

Note: The Daily Observation Unit Benefit amount must be equal to the Daily Hospital Confinement Benefit Amount.

Medical Questions on Application

1. Answer all question as directed;
2. Answer all parts of Questions 1 – 6;
3. Question 1-6 - provide complete details for any yes answer;
4. Question 7 - list any and all prescription medications the insured is taking or has been told to take. If no medications are being taken or been prescribed, write “None”; do not use N/A.

If additional space is needed for details to Question 7 or prescriptions drugs in Question 7, use the additional sheet provided in this application package.

If the Proposed Insured is age 64½ - 65½, skip Questions 1 – 6 and Question 7.

Disqualifiying Medications

Refer to the Disqualifying Medications list on form HI21BFLIC UWG IS to determine eligiblity for coverage.

The medications shown in the Disqualifying Medications list are just some of the more commonly prescribed medications. The medications list is not an all inclusive list. ***If you have an applicant who is taking any of the listed medications for a reason other than that listed, please contact the Underwriting Department for clarification.*** If you have an applicant who is taking one or more medications not found on the list, please contact your Underwriter for an opinion. Medications not listed on the “Disqualifying Medications” list may still disqualify the applicant from coverage.

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

Application for Hospital Indemnity Insurance

Agent/Producer Name	%	Agent/Producer #

Requested Effective Date: cannot be *29th, 30th or 31st* — Month ___ / Day ___ / Year ____

Deliver Policy to:
❑ Insured
❑ Agent/Producer

PROPOSED INSURED INFORMATION (use additional pages if necessary):

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

PRIMARY INSURED CONTACT INFORMATION:

Residence Address (Street or Route & Box #)	Residence City	Residence State	Residence Zip Code
Email Address:	I agree to electronic delivery of notices, including premium notices, unless this box is checked: ❑ send UPS		Residence County
Home Telephone # ( )	Mobile/Cell Telephone # ( )		
Best # to call: ❑ Home ❑ Mobile/Cell	Best time to call:_____ ❑ AM ❑ PM		

BENEFICIARY INFORMATION:

Beneficiary Name	Date of Birth Month/Day/Year	Insured	Relationship to Insured	Primary or Contingent
		Primary insured		Primary
		Primary insured		Contingent
		Spouse or Partner		Primary
		Spouse or Partner		Contingent

Application continued on next page

Application continued from previous page

PLAN/PREMIUM INFORMATION:

Benefit Options:
Hospital Indemnity Policy
Coverage Type: ❑ Insured ❑ Insured & Spouse or Partner ❑ Insured & Child(ren) ❑ Insured & Family
Is Maternity included? ❑ Yes ❑ No Is Mental/Nervous Disorder Included? ❑ Yes ❑ No

**Refer to rate sheet for modal premiums and fees*

		Modal Premium*
Hospital Indemnity Policy	☑ Hospital Admission $_____ ($100 - $5,000; $100 increments)	$_____
	☑ Daily Hospital Confinement $_____ ($100 - $750; $25 increments)	$_____
	Benefit Period (days):	
	❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 15 ❑ 21 ❑ 31	$_____
	☑ Emergency Room ($200)	$_____
	☑ Urgent Care ($50)	$_____
	☑ Observation Room $_____ (must equal Daily Hospital Confinement Benefit)	$_____
	☑ Ambulance: Air $_____ ($100 - $400; $50 increments)	$_____
	Ground/Water $_____ ($100 - $400; $25 increments)	$_____
Optional Benefits	**Benefit Amount**	
	❑ ICU Admission Benefit ..... $ 500	$_____
	❑ Daily ICU Admission Benefit ..... $ 250	$_____
	❑ Rehabilitation Unit Confinement Benefit ..... $ 50	$_____
	Benefit Period ❑ 15 days ❑ 31 days	
	❑ Skilled Nursing Confinement ($100 - $200; $50 increments)..... $_____	$_____
	❑ Daily Outpatient Surgical Benefit	
	Hospital/ASC ($250-$1,000; $250 increments)..... $_____	$_____
	Physician's Office (will equal 20% of Hospice ASC)	
	❑ Minor Diagnostic Exam Benefit ($25 - $100; $25 increments) ..... $_____	$_____
	❑ Major Diagnostic Exam Benefit ($100 - $500; $100 increments) ..... $_____	$_____
	❑ Invasive Diagnostic Exam Benefit ($100 - $500; $100 increments) ..... $_____	$_____
	❑ Non-local Transport Benefit ..... $ 100	$_____
	❑ Family Member Lodging Benefit ..... $ 100	$_____
	❑ Health Screening Benefit ($50 - $100; $25 increments) ..... $_____	$_____

Total Initial Premium Due: $_____

Initial Premium Payment:

Method
❑ Bank Draft ❑ Credit Card
❑ Check or Money Order

Mode
❑ Draft/Charge Upon Approval
❑ Draft/Charge at Effective Date
❑ Draft/Charge at Custom Date*
*Initial Premium Draft/Charge Date:

__ __ / __ __ / __ __
MO DAY YR

Recurring Premium Payment:

Method
❑ Bank Draft
❑ Credit Card
❑ Check or Money Order

Mode
❑ Annual ❑ Semi-Annual
❑ Quarterly ❑ Monthly

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

OR

Requested Draft Schedule
❑ 1st day of the month ❑ 3rd day of the month
❑ 1st Wednesday of the month ❑ 3rd Wednesday of the month
❑ 2nd Wednesday of the month ❑ 4th Wednesday of the month

Application continued on next page

Application continued from previous page

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

1. a) Do you have any supplemental health insurance in force or pending with any company, including individual or group insurance contracts? ❑ Yes ❑ No

b) Do you intend to replace any supplemental health insurance with this policy for which you are applying? ❑ Yes ❑ No

If "Yes", please provide the following information and complete a Replacement Notice, if required:

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

HEALTH INFORMATION

Please record details of all YES answers on the next page and attach a separate sheet if needed. If the Primary Insured is between the ages of 64½ and 65½ years, as of the date of this application, skip this Health Information section.

1. Within the last 12 months, has any Proposed Insured required assistance or supervision of any kind to perform activities of daily living such as bathing, continence, dressing, eating, transferring (getting in and out of a bed or chair), or toileting?	❑ Yes ❑ No
2. Within the last 12 months, has any Proposed Insured been hospitalized as an inpatient, had a nursing home stay, or received home health care due to an injury or sickness (excluding a cold or flu)?	❑ Yes ❑ No
3. Has any Proposed Insured ever been medically 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 last 12 months, has any Proposed Insured had any surgery, medical tests, or treatments recommended by a medical professional but not performed (excluding routine health screenings)?	❑ Yes ❑ No
5. Within the last two (2) years, has any Proposed Insured had an amputation due to disease or had any organ transplant surgery?	❑ Yes ❑ No
6. Within the past three (3) years, has any Proposed Insured been medically diagnosed by, treated by, or consulted with a medical professional for:	
a. a heart attack or any disease or disorder of the heart or vascular system, a stroke or transient ischemic attack (TIA), congestive heart failure, heart or heart valve surgery, bypass surgery, or any device such as a pacemaker or implantable cardioverter defibrillator (ICD) to control heartbeat?	❑ Yes ❑ No
b. cancer, carcinoma in situ, malignant melanoma, Hodgkin's disease, leukemia, lymphoma, sarcoma, or any malignancy except for basal cell or squamous cell skin cancer?	❑ Yes ❑ No
c. emphysema, Chronic Obstructive Pulmonary Disease (COPD), cystic or pulmonary fibrosis, lung disorder requiring oxygen, or any other disease or disorder of the lungs (excluding asthma)?	❑ Yes ❑ No
d. complications of diabetes, insulin-dependent diabetes (excluding gestational) requiring over 50 units of insulin, chronic kidney disease, or any other disease or disorder of the kidneys (excluding kidney stones)?	❑ Yes ❑ No
e. hepatitis B or C, cirrhosis, or any other disease or disorder of the liver?	❑ Yes ❑ No
f. amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), Crohn's disease, systemic lupus, multiple sclerosis (MS), muscular dystrophy (MD), neuromuscular disease, Parkinson's disease, Alzheimer's disease, dementia, or any other cognitive disorder?	❑ Yes ❑ No
g. alcohol or drug abuse or dependency?	❑ Yes ❑ No
h. sickle cell anemia or any chronic blood disorder?	❑ Yes ❑ No

Application continued on next page

Application continued from previous page

Please provide details for all "Yes" responses to Health Information questions, including the proposed insured's name, condition, date of diagnosis, and any types of treatment received or surgeries performed. Use an additional sheet if necessary.

Question #	Proposed Insured Name	Details

PRESCRIPTION MEDICATION INFORMATION (PROPOSED PRIMARY INSURED ONLY):

7. List all prescription drugs You are currently taking or have been prescribed or medically advised to take: *Copy information from pharmacy label.* **If the Primary Insured is between 64½ and 65½ years, as of the date of this application, skip this Prescription Medication section.**

Medication Name	Dosage	Frequency	Condition for Which Prescribed	Currently Taking?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Application continued on next page

Application continued from previous page

SIGNATURE SECTION: Please read the following section, sign and date

8. I, the undersigned Proposed Primary 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 Primary 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. I also authorize Bankers Fidelity Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB, Inc. 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 Primary Insured and Writing Agent/Producer state that the Proposed Primary Insured has read or had read to him or her the completed application and that the Proposed Primary 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 claim for payment or a loss of benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines for criminal penalties.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE 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.

The Proposed Primary 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 Primary Insured's signature

X _____ X _____
Writing Agent's/Producer's signature Spouse or Partner's signature (if applying for coverage)

Application continued on next page

Application continued from previous page

WRITING AGENT/PRODUCER INFORMATION

Does any Proposed Insured intend to replace or change any supplemental health policies with the Hospital Indemnity policy for which they are 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 Primary Insured an outline of coverage for the policy applied for and a *Guide to Health Insurance for People with Medicare*, if any Proposed Primary Insured is age 65 or older.

Is any Proposed Insured related to you?..... ❑ Yes ❑ No

If "YES," explain relationship: ❑ Self ❑ _____

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

Additional Page for Application on:

Applicant Name: _____ **SS#:** _____

Additional Prescription Medications

Medication	Dosage	Condition Prescribed	Currently Taking?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

Details to "Yes" Answers for Health Questions

Question Number	Condition	Date of Diagnosis	Date & Type of Treatment Received

Dated at _____ **on** _____ **X** _____
(City, State) (Date) Proposed Insured's Signature

PROPOSED INSURED

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.

SPOUSE OR PARTNER

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.

SELECT A OR B

A. ❑ CHECKING AUTHORIZATION ❑ SAVINGS ACCOUNT AUTHORIZATION

Name of Financial Institution:		Type of Financial Institution: ❑ Bank ❑ Credit Union
Routing/ABA Number:	Account Number:	**Attach a voided check if the account number is different than the account number on the initial premium. If the authorization is for a Savings Account, attach a deposit slip.**
Signature of Account Holder	Date	

B. ❑ CREDIT CARD AUTHORIZATION

Type of Card: ❑Mastercard ❑ Visa ❑ Discover	Account Number:	
Name of Card Holder as it appears on account		Expiration Date ___/___ Month Year
Signature of Card Holder		Date

B 0129 MBD/CC (8-03)

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., 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. 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.

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.

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DETACH AND LEAVE THIS PAGE WITH THE APPLICANT.

Notes:

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