Bankers Fidelity Life Insurance Company®

Field Agent's **Underwriting Guide**

Underwriting companies:
Bankers Fidelity Life Insurance Company®
Bankers Fidelity Assurance Company®
Atlantic Capital Life Assurance Company™ d/b/a Bankers Fidelity

Underwriting Philosophy

At Bankers Fidelity®, we strive to provide you with a solutions-oriented underwriting team who work in conjunction with your efforts to achieve sales success.

Our focus is on exemplary, responsive service as we partner across the organization, and with sales distribution, to provide effective risk management. This results in a growth of income for both the company and our agents.

Our ambition is to build a company of lasting value that you can depend on, and we work towards achieving our goals each and every day.

Bankers Fidelity®

Contact Information

New Business Mailing Information:

Send via USPS, Overnight, or Certified to:
Bankers Fidelity
Attention: New Business
4370 Peachtree Road NE
Atlanta, GA 30319

Telephone Numbers:

Agent Support	866-458-7503
Marketing	866-458-7505
Underwriting/New Business	866-458-7501
Policyholder Services	866-458-7500
Claims	866-458-7499
Hours of Operation:	8:00 a.m. – 5:30 p.m. EST Monday – Thursday 8:00 a.m. – 5:00 p.m. EST Friday

Email Addresses:*

Agent Support	agentsupport@bflic.com
Policyholder Services	bflphs@bflic.com
Agency	bflagency2@bflic.com
New Business Applications	bfluw@bflic.com
Questions for Underwriting Only	underwriting@bflic.com

New Business Fax Numbers:**

Main	404-926-4030
Alternative	877-739-1804

*Do NOT email applications from unsecured email accounts. You may use the secured email section within the ADDS® portal if needed.

**If faxing in applications, please do NOT also mail in original paperwork. Only applications paying the initial premium by bank draft or credit card are eligible to be emailed or faxed.

Proposed Insured:

The Proposed Insured is the specific individual on whose life and health the underwriting decision is made. In certain situations, a person other than the Proposed Insured may be submitting the application for the coverage on the Proposed Insured; this person is the Applicant. Life insurance policies also have an Owner, who may be someone other than the Proposed Insured. Throughout this document we refer to the Proposed Insured. However, in situations where correspondence is legally required to be sent to the Owner or Applicant, that reference is hereby inferred.

Submission Process

SITUATION	SUBMIT APPLICATION NO EARLIER THAN...
Fully Underwritten / Guarantee Issue	3 months before the requested effective date
Open Enrollment	6 months before the requested effective date

The Application

There are several important points you should remember when completing an application.

Agent Section

1. Ensure the correct agent number, corresponding to the company, is included on the top right corner of the first page of the application.

Applicant Section

2. Residence address is required on the application to reflect the individual insured's residence address, PO Boxes may only be used as the mailing address.
3. Answer all of the questions on the application, fill in all of the blanks, obtain all necessary signatures and dates on all forms.

Required Forms

4. A completed and signed HIPAA Authorization form is needed with every application (with the exception of Open Enrollment, Guarantee Issue and internal replacements).
5. Use the most current forms (i.e., applications, replacement notices, authorizations, etc.) approved for use in the state(s) in which you are licensed and in which the application is signed by the Proposed Insured. Remember, all forms are located in the ADDS Library where they may be downloaded, printed and ordered.

Medical Section

6. Ask the Proposed Insured each question exactly as written on the application. Pay particular attention to the time frame indicated.

   For all medical/health questions, ask "has Proposed Insured had or been medically diagnosed with or treated for":

   - "Had" means the Proposed Insured currently has or has had a medical condition in the past, in the time frame indicated.
   - "Treated for" means the Proposed Insured has been treated for a condition/impairment within the applicable time frame noted on the application (regardless of the original diagnosis date of the condition). Also note that any current medical observation or continued care for a noted condition is also applicable.
   - "Medically diagnosed with" means the Proposed Insured has been diagnosed with a medical condition by a member of the medical profession within the time frame.

7. When filling out the prescription drug list section on the application, list all currently prescribed medications, whether taking them as prescribed or not. Prescription information should be obtained directly from the label on the bottle. If no medications are currently prescribed, write "None". "N/A" and "Not Applicable" will not be accepted.

Commonly Missed Information

- Proposed Insured's telephone number and email address
- Tobacco Use
- Height/Weight
- Medications listed with reasons prescribed or if no medications taken, listed as "None"
- Doctor/Physician name, address and telephone number

Submission Guidelines

1. Applications must be received within 30 days of the date the application is signed. Once received, the application is valid for 90 days from the date signed.
2. The effective date of any policy can be no more than 90 days after the application date, except for 6-month open enrollment cases where the effective date can be 6 months after the application date. Backdating is not permitted.
3. Applicants must initial all changes made on the application. Any changes not initialed by the applicant will require a signed amendment.
4. The policy effective date and the draft date may not be on the 29th, 30th or 31st of the month. If one of these dates is requested, the effective date will be moved to the 1st of the following month.
5. Rates are determined by:
   - The state in which the application is physically signed by the Proposed Insured and requires the agent to be licensed and appointed in the application signed state.
   - Medicare Supplement rates are based on the resident state of the applicant. Applications must be written and signed in the applicant's resident state.

Non-Tobacco Status

In order to qualify for non-tobacco rates, the Proposed Insured must not have used tobacco or nicotine products in any form within the time frame listed on the application. If Proposed Insured uses e-cigarettes or vaporizers, or smokes cigars or pipes (regularly or occasionally), then they will be considered as a tobacco user. Marijuana use is considered a decline.

Initial Premium Payment

In the section on the application titled "Initial Premium Payment":

- Elect method for paying the initial premium.
- Indicate the date the initial premium should be drafted. If no initial draft date is indicated on the application, the initial draft date will be done on the effective date of the policy.*
- Payment is required either on or prior to the effective date.
- Applications should be accompanied with check, draft or credit card. C.O.D. is not acceptable.

*Note: Dates for future recurring draft payments can be different than the initial premium draft date.

Recurring Premium Payment

- The recurring premium payment due date is the same day of the month as the effective date of the policy. The policyholder has a 30-day grace period in which to make a premium payment without the policy coverage lapsing.

Payment Methods

Payments may be made by check, credit card or money order. Bankers Fidelity will not accept cash or the agent's personal check or credit card as a form of payment.

Checks

Checks should be payable to Bankers Fidelity. Make sure to include a voided copy of a check for bank drafts. Post dated checks are not permitted.

Credit Cards

We accept American Express, Mastercard, VISA and Discover.

Effective Date of Insurance

Please remember that there is no insurance coverage in effect until all underwriting requirements are satisfied, the policy has been issued, received by the owner, and the first premium is paid and honored upon first presentation – all during the Proposed Insured's lifetime and before any change in the Proposed Insured's health as stated on the application.

Household Discount

A Household Premium Discount is available to qualified applicants on several of our health insurance products, including Medicare Supplement, Vantage Flex 65® and Vantage Recovery®. The discount percentage amount can be found on the rate sheets for the products on which it is available.

Medicare Supplement

Qualified Applicants*:

- are married and residing with their spouse; or
- have been residing with at least one other person, but not more than three other persons, who are all aged 50 or older, for at least the last 12 consecutive months.

*CO, IN, KY, MD, NJ, NM, OH, PA and VA – at least one other person must have or is also applying for a Medicare Supplement policy issued by us.

Discontinuation of Household Discount*

The Household Discount will be discontinued if, other than in the event of the other person(s) death**, the Insured:

- is no longer residing with their spouse; or
- is no longer residing with at least one other person who is aged 50 or older; or
- is residing with more than three other persons regardless of age.

*KY, NV & TN – the Household Discount rider does not terminate once qualified
**OH – the Household Discount rider terminates at death

A Medicare Supplement policy issued to someone under age 65 and disabled may be used to qualify a Medicare Supplement applicant age 65 or over for the discount, but the policy that was issued to the person under age 65 and disabled is not eligible to receive the discount (except in Kansas and Montana).

A Medicare Supplement policy issued to someone prior to June 1, 2010 may be used to qualify a current applicant age 65 or over for the discount, but the policy issued prior to June 1, 2010 is not eligible to receive the discount.

Requirements

Proposed Insureds must complete the "Household Discount Information" section in the application in order to be considered for the Household Discount. Upon issuance of the policy to the second policyholder, both policies, if qualified, will receive the appropriate discount.

Discontinuation of Household Discount*

The Household Discount will be discontinued when there is only one active policy remaining in the household. This occurs when:

- The other policy in the household becomes inactive, other than due to death**; or
- The individuals no longer reside in the same household, unless married.

*KY, NV & TN – the Household Discount rider does not terminate once qualified
**OH – the Household Discount rider terminates at death

The Household Discount is available to persons with the same type of policy issued by Bankers Fidelity Life Insurance Company® and any of its subsidiaries or affiliates, subject to the above provisions.

Underwriting Process

Telephone Interviews

Contact information:

Phone: 866-235-7580

Hours of Operation:

Monday - Friday: . . . . . .8:00 a.m. – 9:00 p.m. CST

Saturday: . . . . . .9:00 a.m. – 3:00 p.m. CST

Sunday: . . . . . .Closed

Telephone Interview Process

Medicare Supplement/ Vantage Flex *Plus*/ Vantage Care™/ Life/ Vantage Recovery®/ Vantage Flex 65®

Underwriting reserves the right to order a telephone interview on any product if necessary to obtain additional information.

- The interview with the applicant takes approximately ten (10) minutes. It is important to note that the dialogue between the applicant and phone interviewer will be recorded and relied upon as part of our risk analysis.
- Applications are selected randomly for telephone interviews.
- The telephone interview for these products is ordered by the Home Office only and excludes the following:
  - Open Enrollments, Guarantee Issue, or conversions between Bankers Fidelity Life Insurance Company®, Bankers Fidelity Assurance Company®, and Atlantic Capital Life Assurance Company™ if the existing policy has been in force for at least 1 year.

Additional Underwriting Requirements

Attending Physician Statement (APS)

Underwriting may find it necessary to order medical records or an Attending Physician Statement to provide further information on responses given on the application or obtained through the telephone interview. Clarification may also be requested through contact from the Proposed Insured's primary care physician.

Prescription Drug Search (Rx)

A prescription drug search is part of the underwriting review process. This information is reviewed and assessed for an individual's risk and eligibility and is used by the underwriter to validate any errors, omissions or misrepresentations made on the applications.

Medical Claims Data

This is billing data submitted by hospitals and other providers for payment on the services they render. This information provides underwriters with condition and treatment information, much of which will not show up in prescription records.

Doctor/Physician Statement

Underwriters at times may require additional clarification on medical history and will request a Doctor/Physician's statement.

When providing the letter/statement, it should be:

- Provided on the Doctor/Physician's office letterhead
- From the prescribing Physician
- Noting specific condition for which medication was prescribed
- Noted that patient is not diagnosed with specific declinable condition

Open Enrollment

The Open Enrollment period is the 6-month period which begins on the first day of the month in which the Proposed Insured is both age 65 or older* and enrolled in Medicare Part B. If the Proposed Insured's birthday is on the first day of the month, their Part B coverage (and Medicare Supplement coverage) may begin on the first day of the prior month.

Applications will be accepted up to 6 months prior to the Part B effective date.

- HIPAA form and telephone interview are not required.
- Health questions should not be answered.
- If applying for U65 Medicare Supplement, a copy of the applicant's Medicare card is required.

*Some states extend this to applicants under age 65, refer to the state application.

The tobacco question must be answered for all underwritten applications. The chart below indicates the states where the tobacco questions must be answered for open enrollment or guarantee issue.

BFLIC, BFAC and ACLAC OE/GI TOBACCO

Alabama	Indiana	South Dakota
Arizona	Kansas	Texas
Colorado	Mississippi	West Virginia
Delaware	Montana	Wyoming
Dist. of Col.	Nevada	
Georgia	Oklahoma	

63–Day Guarantee Issue

There are several scenarios that fall under the 63-day Guarantee Issue provision and these may be found in the current "Choosing a Medigap Policy" booklet from CMS.

- 6 month GI for TN; 90-days GI in WY.
- Plan availability varies by situation determining eligibility.
- Must include a termination letter showing the Proposed Insured's current plan's termination date and the reason for termination.
- HIPAA form and telephone interview are not required.
- Health questions should not be answered.
- Replacement form may be required unless it's due to losing group health coverage.

Acceptable Proof for Medicare Supplement Guaranteed Issue

Losing group health coverage

- Involuntary: A letter from the Employer, Union, or Carrier stating the applicant has involuntarily lost their coverage as of MM/DD/YYYY and the reason why the coverage is being lost.
- Voluntary: If terminating coverage voluntarily (applicable in AR, ID, IN, KS, LA, MO, NJ and TX* only).
  *TX – Only if the plan they left was primary to Medicare.
- Documentation from the carrier or employer showing the termination date of coverage.

Examples of Documentation

Losing Medicare Select or Medicare Advantage plan due to moving out of service area

A letter stating the Proposed Insured has moved out of the area is required and termination date, proof of the coverage they had, and proof that the plan is not offered where they currently reside (i.e. a print out of the service area from the Medicare Select or Medicare Advantage plan's website) will be required.

Losing Medicare coverage through no fault of their own

Proof from Medicare or the current carrier the Proposed Insured is losing their coverage through no fault of their own and termination date is required.

Loss of Medicaid (KS, TN and TX only)

A letter from Medicaid stating the Proposed Insured is losing their coverage and the termination date is required. The reason why they are losing coverage will have to satisfy the state requirements.

Losing Medicare Advantage plan because plan is no longer being offered

A letter from Medicare or the Medicare Advantage plan stating the plan is no longer being offered and the termination date is required.

Losing Medicare Advantage plan in trial period (Joining when first eligible for Medicare)

- Letter from Medicare OR Medicare Advantage confirming the disenrollment and the termination date is required.

Losing or Discontinuing Medicare Advantage plan in trial period (Former Medicare Supplement Plan no longer available)

- Disenrollment letter from Medicare or the Medicare Advantage plan confirming disenrollment and the termination date is required.
- Proof of the plan the applicant previously had (i.e. letter from previous Medicare Supplement carrier stating plan, or ID card) or proof showing the applicant's previous plan is no longer available (i.e. letter from previous carrier, or information from the carrier website) and the termination date is required.

Discontinuing Medicare Advantage plan for being misled

A letter from Medicare giving the Proposed Insured approval to leave the Medicare Advantage plan for being misled is required.

Replacements

A "replacement" occurs when an applicant wishes to terminate or in any way alter an existing in-force insurance policy during the course of applying for a new policy with Bankers Fidelity. Altering an existing in-force policy can include such actions as reducing or increasing the benefits (health) or the face amount (life), placing a whole life insurance policy on extended term or reduced-paid up, lowering or changing premium payments on investment-based or annuity contracts, or anything else that changes the previously arranged benefit of the policy to the insured.

Replacements can be "Internal" or "External":

- Internal Replacement – Replacing an existing policy for a new policy within the same or affiliated company
- External Replacement – Replacing an existing policy with another company for a new policy with Bankers Fidelity: i.e.: another (outside) company to either BFLIC, BFAC or ACLAC

Requirements:

To process an application for replacement coverage, we require the following fully completed forms:

- Application and any required supplements
- Authorizations as necessary – HIPAA, bank draft, etc.
- Replacement Form – required on external replacements for:
  - all Medicare Supplement; the separate Comparison Statement is also required in IL and KY, the Disclosure form is required in OH
  - all Life Insurance
  - Health Insurance – varies by state and product; refer to ADDS

External replacements may require a telephone interview to be completed (see telephone interview process).

On Internal replacements, we will also review the medical history in our claims records, as well as the claims loss ratio of the existing policy.

Bankers Fidelity does not accept 1035 exchanges for new business.

NOTE: Bankers Fidelity cannot contact a policyholder's previous carrier to cancel or otherwise change their existing coverage. It is the policyholder's responsibility to notify their existing carrier of their intent to cancel or otherwise change coverage. Bankers Fidelity is not liable for any monetary loss the policyholder may incur for failure to cancel or change existing coverage.

It is prohibited for an individual to have duplicate Medicare Supplement policies. It is therefore extremely important that the policyholder notify their existing carrier of their intent to cancel their policy with them prior to the effective date of any policy issued by Bankers Fidelity.

Conversions

If you write a current policyholder another plan and are not the original writing agent, we require a handwritten letter from the client with their signature stating that they wish to change agents emailed or faxed to the Policyholder Services department.

Reinstatement Guidelines

- When a health insurance policy has lapsed and it is within three (3) months of the last paid to date, coverage may be reinstated, based upon meeting the current underwriting requirements.
- Whole Life coverage may be reinstated if the policy has lapsed and is within 60 months of the last paid to date.
- When applying for reinstatement of coverage, please have the Proposed Insured complete the appropriate reinstatement application.
- When a health insurance policy has lapsed for more than three (3) months beyond the last paid to date, the coverage cannot be reinstated. The client may, however, apply for new coverage.
- All underwriting requirements must be met before a new policy can be issued.
- No coverage is in effect and no benefits are payable until the policy is reinstated.

Medications

The medications listed in the "Disqualifying Medications" section of each product's underwriting guidelines disqualify the Proposed Insured for insurance and the application should not be submitted. The medications listed in the "Preferred Underwriting Disqualifying Medications" section may disqualify the Proposed Insured from a Preferred Underwriting classification.

The combination of several medications, which may not be considered disqualifying on their own, may cause the Proposed Insured to be disqualified from coverage or the Preferred Underwriting classification.

If a Proposed Insured is taking any of the listed medications for a reason other than that listed or is taking a combination of medications for a condition, please notate the condition for which it was prescribed within the appropriate section on the application.

The "Disqualifying Medications" lists contain the more common medications that are disqualifying for each product but is not meant to be all inclusive. Other medications that are not listed may disqualify an applicant for coverage.

Decision Process

Other than applications that are approved, the following Underwriting decisions may be made:

Amendments

An amendment to the application will be generated for the following reasons:

- Any health question left blank
- Any question answered incorrectly on the application
- An error or unclear answer for the date of birth or plan being applied for
- A change made to the application that is not initialed by the Proposed Insured
- Premium calculation error

Counteroffers

If an application needs to be moved to a different rate class, a counteroffer will be sent to the agent via email. If accepted, the counteroffer is made in the form of an amendment that must be signed by the agent and the applicant.

Policies will not be considered in force until Bankers Fidelity receives the signed amendment. Amendments not received back within 15 days of the amendment being sent to the agent will result in the application being withdrawn and a new application would need to be submitted. The signed amendment may be sent back by email, fax or mail.

Premium Shortages

If the initial premium is short within allowable limits, the policy will be issued with a C.O.D., which is a requirement of additional premium due. A letter will be mailed with the policy to the agent. If the additional premium is not received within 15 days, the policy will be withdrawn and the initial premium refunded to the payor. The policy will not be in force until we receive the additional payment due.

If the initial premium is short outside allowable limits, the application will be considered not in good order (see below).

An agent cannot deduct premium shortages or policy fees from their commission.

Applications Not in Good Order

If there is insufficient information on the application, the agent will be contacted during the application process to obtain additional information. If the information is not received within 30 calendar days of the application signed date, the application is terminated as incomplete and a letter will be sent to the applicant and agent. Any refund of premium will be returned to the payor.

Withdrawn Applications

Applications will be withdrawn for the following reasons:

- The Proposed Insured does not recall filling out the application.
- The application was filled out and signed by a third party without providing a binding Power of Attorney.
- The application was taken by an agent who was not licensed and appointed at the time of solicitation in the state of application.
- The Proposed Insured is unable or unwilling to complete the telephone interview.
- Additional forms requested by the underwriter are not submitted within the allotted time frame.
- The Proposed Insured cannot or will not provide information regarding a medical condition for which a medication has been prescribed.
- For Medicare Supplement, if app signed state is not the same as the residence app state.

Declined Applications

Proposed Insureds will be notified via mail of a declination with the agent copied via email. If an application is declined, you may request a reason for the declination.

- If the reason for decline was disclosed on the application, we are able to release this information verbally to both the agent and Proposed Insured.*
- If the reason for decline came from a doctor's letter, medical records, or information obtained directly from a physician – we will only release the reason for declination to a physician of the Proposed Insured's choice. This request should be in writing indicating the name, address and phone number of the physician and signed by the Proposed Insured.
- If the reason for decline came from prescription search results, telephone interview and/or medical data, we will release the reason for declination to the applicant. This request can be made in writing.

*We will not disclose non-public, personal health information (PHI) or any other private information to an agent unless the "Authorization for Release of Information to My Insurance Agent and/or Agency" has been signed by the Proposed Insured.

Refunds

All refunds are made directly to the Payor in the event of declination, incomplete submission, cancellations, etc. A full refund of the premium submitted with an application will be processed 21 days after the date the check was deposited (to ensure the check has cleared the bank).

A new application will need to be completed once the 30 calendar day period has lapsed.

Application status can be checked through ADDS.

Required Forms

It is important to use the current, approved form for the state in which the application is being signed. Current forms may be ordered from the Company or printed directly from ADDS. Forms should be completed in their entirety, with all questions answered and all blanks filled in; incomplete forms will be sent back to the agent with instructions on the necessary corrections.

The following forms should be submitted to Underwriting:

Application – only the current, state-approved applications can be accepted by Underwriting. Discontinued or out-of-date applications will be returned to the agent with instructions to complete a new application.

Authorization for Drafts/Withdrawals/Charges Form – required if premiums are to be paid by automatic bank draft or credit card. If paying via Bank Draft, include a copy of a voided check.

Family Billing Form – required if two or more policies are going to be drafted from the same account or billed on the same invoice.

HIPAA Authorization Form – required with every application, with the exception of Open Enrollment, Guarantee Issue and internal conversions.

Replacement Notice – required on

- all Medicare Supplement
- all Life Insurance
- Health Insurance – varies by state and product

The following forms should be left with the Proposed Insured regardless of whether an application is written:

Guide to Health Insurance for People with Medicare – should be left with all prospective clients and/or applicants age 65 and over on any health insurance product.

Life Insurance Buyer's Guide – should be left with all prospective clients and/or applicants on all life cases.

Notice to Applicant – Part One and Part Two – should be left with the Proposed Insured when taking applications on all products.

Premium Receipt – should be completed and left with the Payor only if initial premium is collected with the application.

Replacement Notice – a copy of the completed Replacement Notice should be left with the Proposed Insured.

Additional Product-Specific Multi-State Forms:

Accelerated Death Benefit Disclosure – This form is required on all Whole Life applications in the states of: AL, AR, IL, IN, KS, LA, MA, MI, MN, MS, MT, NE, NC, OH, OK, OR, PA, VA and WA. A copy of the completed form should be left with the Proposed Insured.

Medicare Supplement Application Supplement – These forms are required and required to be submitted with all Medicare Supplement.

- Application Supplement in the states of MD, PA, TX
- Guarantee Issue Annual Open Enrollment Birthday Rule: KY, LA, MD, NV

Additional State-Specific Forms:

Florida – Unintentional Lapse Designation Form. This form must be completed and submitted on all life cases.

Illinois – Medicare Supplement Checklist. This form must be completed and submitted with all replacement cases; copy to be left with the Proposed Insured.

Kentucky – Medicare Supplement Comparison Form. This form must be completed and submitted with all replacement cases; copy to be left with the Proposed Insured.

Maine – Unintentional Lapse Designation Form. This form must be completed and submitted on all life cases.

Ohio – Solicitation of Medicare Supplement Insurance Disclosure. This form must be completed and submitted with all Medicare Supplement applications; copy to be left with the Proposed Insured.

Pennsylvania – Disclosure Statement. This cash value worksheet must be completed with all life applications; original submitted to Underwriting, a copy is to be left with the Proposed Insured.

Virginia – Notice About Attained Age Rated Medicare Supplement Policies. This form must be completed and submitted with all Medicare Supplement applications; copy to be left with the Proposed Insured.

Policy for Agents Writing Business on Themselves or Relatives

Agents may write policies on themselves or relatives within the following guidelines:

- Cancer, HIP, STC, Med Supp and Life
- Should an active policy written by an agent on a relative or themselves lapse, the policy cannot be rewritten without the approval of the President of BFLIC/BFAC/ACLAC or the Vice President of Marketing.

Uninsurable Conditions

Medicare Supplement

- **A** A-Fib
- AIDS/ARC/HIV
- Alzheimer's Disease
- Amputation due to disease
- Amyotrophic Lateral sclerosis (ALS)
- **B** Bi-Polar Disorder
- **C** Cancer
- Cardiomyopathy
- Chronic Bronchitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Cirrhosis
- Cognitive Impairment
- Congestive Heart Failure (CHF)
- Crohn's Disease
- **D** Defibrillator
- Diabetic Complications
- **E** Emphysema
- **H** Huntington's
- **I** Insulin use >50 units/day
- **K** Kidney Disease/Insufficiency
- **L** Leukemia/Lymphoma
- **M** Melanoma
- Multiple Sclerosis (MS)
- Myasthenia Gravis
- **O** Organ Transplant
- **P** Parkinson's Disease
- Peripheral Vascular Disease
- Polycythemia Vera
- Primary Biliary/Sclerosing Cholangitis
- Pulmonary Fibrosis
- **R** Rheumatoid Arthritis
- **S** Schizophrenia
- Systemic Lupus
- Systemic Scleroderma (CREST)
- Supplemental Oxygen Use
- **U** Ulcerative Colitis
- **W** Wheelchair/Walker Use

Vantage Recovery

- **A** AAIDS/ARC/HIV
- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- **B** Bi-polar Disorder
- **C** Cancer
- Cardiomyopathy
- Chronic Bronchitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Cirrhosis
- Cognitive Impairment
- Congestive Heart Failure (CHF)
- Crohn's Disease
- **D** Defibrillator
- **E** Emphysema
- **H** Huntington's disease
- **I** Insulin use >50 units/day
- **K** Kidney Disease/Insufficiency
- **L** Leukemia/Lymphoma
- **M** Melanoma
- Multiple Sclerosis
- **O** Open Colostomy
- Open Ileostomy
- **P** Parkinson's Disease
- Polycythemia Vera
- Primary Biliary/Sclerosing Cholangitis
- **S** Supplemental Oxygen Use
- **U** Ulcerative Colitis
- **W** Wheelchair/Walker Use

Vantage Flex *Plus*

- **A** AIDS/ARC/HIV
- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- **C** Cancer
- Cardiomyopathy
- Chronic Bronchitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Cirrhosis
- Cognitive Impairment
- Congestive Heart Failure (CHF)
- Coronary or Carotid Artery Disease
- Crohn's Disease
- **D** Defibrillator
- Diabetic Complications
- **E** Emphysema
- **I** Insulin use >50 units/day
- **K** Kidney Disease/Insufficiency
- **L** Leukemia/Lymphoma
- **M** Melanoma
- Multiple Sclerosis
- **P** Pacemaker
- Parkinson's Disease
- Peripheral Vascular Disease
- Polycythemia Vera
- **S** Supplemental oxygen use
- Systemic Lupus

The Strength of Experience

At Bankers Fidelity, we conduct our business according to a strong set of guiding principles.

For more than 65 years, we have been honored to provide tens of thousands of Americans with valuable, customer-focused insurance products.

Our commitment to fair and fast payment of claims has earned us a reputation for delivering quality service to our policyholders and their families.

You can rely on our reputation as a Company that consistently makes good on its promises to every single policyholder.

Bankers Fidelity is rated A- (Excellent) by A.M. Best Company.*

*Best Rating Report; prepared by A.M. Best Company; www.ambest.com.
The rating refers only to the overall financial status of the Company and is not a recommendation of the specific policy provisions, rates or practices of the insurance company.

Bankers Fidelity®

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www.bankersfidelity.com

Bankers Fidelity Life Insurance Company®, Bankers Fidelity Assurance Company® and Atlantic Capital Life Assurance Company™
4370 Peachtree Road, NE, Atlanta, GA 30319
Agent toll-free number 866-458-7503
www.bankersfidelity.com
Rates subject to change on a class basis. Application to determine eligibility required; not all products available in all states.