

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## AccumUL Plus Checklist – Texas

Please mail application and appropriate forms to: United of Omaha Life Insurance Company,  
Attn: Individual Life Underwriting, 9330 State Hwy 133, Blair, NE 68008

### **PRODUCER MUST ALSO SIGN ALL APPROPRIATE REQUIRED FORMS**

- Leave all applicable forms with the Applicant/Owner**
- Be sure the application is signed and dated in Section M on page 12 by the Applicant /Owner**
- Monthly Bank Withdrawals**  
For Bank Service Plan (BSP), indicate whether the full modal premium was submitted by checking the appropriate box on the Monthly Bank Withdrawals form.
- Temporary Life Insurance Agreement (TIA) Reminders** – The Producer is required to sign and date the Temporary Insurance Agreement when no money can be collected. If money can be collected, the Temporary Insurance Agreement must be completed, dated and signed by the Producer and the Applicant/Owner.
- Have Client Sign ‘Authorization to Disclose Personal Information’ (HIPAA Authorization)**
- Have Client Sign Accelerated Benefit Disclosure form**
- For Mutual of Omaha career agents only, attach copy of Financial Profiles printout**
- Attach copy of the cover letter (if appropriate)**
- Have Client sign HIV Consent Form, if applicable**
- Have Client sign any state specific forms if applicable**
- Have Client Sign any state replacement forms (if applicable) and provide copy to client**  
NOTE: for states requiring Replacement Form L6232, this form must be completed if any existing coverage is listed on the application in the "Other coverage and Replacement Information" section, EVEN IF THIS IS NOT A REPLACEMENT.
- Attach a signed illustration, certification form, or the acknowledgement form if applicable**
- Provide Client with MIB Group, Inc. Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Investigative Consumer Reports Notice, Summary of Rights and Buyer’s Guide**
- If a Proposed Insured age 65 or over applies for a face amount of \$1 million or more, have Applicant/Owner and Proposed Insured sign both the Statement of Policyowner Intent form and the Premium Funding and Acknowledgement form**
- Complete the Oral Fluid Test or schedule Paramed examination, as applicable**  
APPS                    1-800-635-1677                    PORTAMEDIC                    1-800-765-1010
- Indicate underwriting requirements initiated or completed on the Proposed Insured(s)**

<b>Primary Proposed Insured</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Oral Fluid Test</li><li><input type="checkbox"/> Blood Profile</li><li><input type="checkbox"/> Urinalysis</li><li><input type="checkbox"/> Physical Data</li><li><input type="checkbox"/> Long Form Exam</li><li><input type="checkbox"/> EKG</li><li><input type="checkbox"/> Treadmill EKG</li><li><input type="checkbox"/> Inspection Report</li><li><input type="checkbox"/> MD Exam</li></ul>	<b>Other Proposed Insured</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Oral Fluid Test</li><li><input type="checkbox"/> Blood Profile</li><li><input type="checkbox"/> Urinalysis</li><li><input type="checkbox"/> Physical Data</li><li><input type="checkbox"/> Long Form Exam</li><li><input type="checkbox"/> EKG</li><li><input type="checkbox"/> Treadmill EKG</li><li><input type="checkbox"/> Inspection Report</li><li><input type="checkbox"/> MD Exam</li></ul>
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- Comments and Additional Information . . . please list**

Section 2

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## **NOTE: ONLY TWO PEOPLE CAN APPLY ON ONE APPLICATION**

### ■ **APPLICATION**

#### **SECTIONS A AND B: GENERAL INFORMATION**

- Please provide complete name, address, and Social Security Number. Answer all other questions in this section in full
- Use Age Last Birthday
- All changes should be initialed by the Applicant/Owner

#### **SECTIONS C THROUGH F**

- Complete Section C for Juvenile Coverage (Complete only if Primary Insured is a juvenile)
- Complete Section D Underwriting Information
- Complete Section E Additional Details and Explanations
- Complete Section F Personal Finances

#### **SECTION G: OTHER COVERAGE AND REPLACEMENT INFORMATION**

- All details of other coverages (inforce or being applied for) must be listed.

#### **SECTION H: BENEFICIARY INFORMATION**

- Complete all Beneficiary information including relationship and Social Security Number

#### **SECTION I: ADDITIONAL COMMENTS**

- Please provide additional information when necessary

#### **SECTION J: PLAN INFORMATION**

- Complete the plan information and select any optional riders

#### **SECTION K: PLAN INFORMATION**

- Complete for Dependent Children's Rider

#### **SECTION L: PREMIUM AND BILLING INFORMATION**

- Complete amount collected, modal premium, and select mode of payment
- Complete PRD or Association if applicable

#### **SECTION M: AGREEMENT - PLEASE READ AND SIGN**

- Please request the Applicant/Owner read the entire Agreement section before signing
- All Applicant(s)/Owner(s) need to sign this section.
- Any alterations to this section will not be accepted

### **TO THE PRODUCER:**

- Attach copy of the cover letter (if appropriate)
- Complete the Application and, if applicable, the Temporary Life Insurance Agreement and Receipt. See the Life Insurance Temporary Insurance Agreements Guidelines on next page
- Complete the BSP form
- Tear off and discuss the MIB Group, Inc. Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Summary of Rights Under the Fair Credit Reporting Act and Investigative Consumer Reports pages and give them to the Proposed Insured
- Have the HIPAA Authorization to Disclose Personal Information to United of Omaha Life Insurance Company signed and dated and return the Authorization to the Home Office
- Assure that all applicable questions are answered in clear, printed fashion
- Be sure the application is signed by the Applicant/Owner
- Any changes should be initialed by the Applicant/Owner

## **LIFE INSURANCE TEMPORARY INSURANCE AGREEMENT (TIA) GUIDELINES:**

### **IMPORTANT:**

- 1 If the client(s) does/do not qualify for a TIA, both copies of the TIA must be submitted to the Home Office with the Application.
- 2 If the client(s) does/do not qualify for a TIA but incorrectly sign the TIA, a line should be drawn through the TIA form and initialed by the Applicant/Owner to evidence that a TIA has not been provided. Both copies of the TIA must be submitted to the Home Office with the application.

### **DO NOT COLLECT PREMIUM IF:**

- The total amount of insurance applied for on any one individual is greater than \$500,000 or
- The answer to any of the four questions on the TIA is "Yes."

### **IF NO PREMIUM IS COLLECTED THEN:**

- 1 Check the box on the TIA form in the middle of the form indicating no money was collected
- 2 Insert the name(s) of the Proposed Insured(s)
- 3 Sign the TIA on the Producers' Signature line in the middle of the form and insert the date
- 4 Do Not have the client(s) sign the TIA
- 5 Submit both copies of the TIA to the Home Office with the Application

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### **IF THE REQUIREMENTS FOR A TIA ARE MET AND PREMIUM IS COLLECTED THEN:**

- 1 Complete the TIA form
- 2 Insert the date
- 3 Obtain the Applicant/Owner and Proposed Insured signatures
- 4 Submit the original copy of the TIA to the Home Office with the Application
- 5 Leave one copy of the completed TIA form with the Applicant/Owner

## **FINANCIAL INSTITUTION CONSUMER DISCLOSURE**

If this insurance product or annuity is sold, solicited, advertised or offered to a customer at an office of the financial institution, or on behalf of the financial institution, the "Financial Institution Consumer Disclosure" form must be presented and signed at the time of application, and a copy provided with the submitted application.

Activities on behalf of a financial institution include activities where a person, whether at the office of the financial institution or at another location, sells, solicits, advertises, or offers an insurance product or annuity and at least one of the following applies:

- The person represents to a consumer that the sale, solicitation, advertisement or offer of any insurance product or annuity is by or on behalf of the financial institution,
- The financial institution refers a consumer to a seller of insurance products and annuities and the financial institution has a contractual arrangement to receive commissions or fees derived from a sale of an insurance product or annuity resulting from that referral, or
- Documents evidencing the sale, solicitation, advertising, or offer of an insurance product or annuity identify or refer to the financial institution.

# Application for Life Insurance

## UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY  
Mutual of Omaha Plaza, Omaha, NE 68175

- |  |  |
|--|--|
| <input type="checkbox"/> ADULT LIFE                          | <input type="checkbox"/> New Business    |
| <input type="checkbox"/> JUVENILE LIFE                       | <input type="checkbox"/> Term Conversion |
| <input type="checkbox"/> Replacement or                      |  |
| <input type="checkbox"/> Rate Reconsideration                |  |
| <input type="checkbox"/> Addition to Existing Policy # _____ |  |



### SECTION A PROPOSED INSURED INFORMATION

USE BLACK OR BLUE INK AND ALL CAPITAL LETTERS

- Proposed Insured \_\_\_\_\_  
First Name Initial  
 \_\_\_\_\_  
Last Name
- Social Security Number \_\_\_\_\_ Age \_\_\_\_\_  Male  Female
- Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Birth State \_\_\_\_\_  
mo day yr
- Driver's License Number \_\_\_\_\_ State of Issue \_\_\_\_\_
- Legal Residence Address \_\_\_\_\_  
Street  
 \_\_\_\_\_  
City State ZIP
- Mailing Address (if different than above) \_\_\_\_\_
- Phone Number (\_\_\_\_) \_\_\_\_\_ Alternate Phone Number (\_\_\_\_) \_\_\_\_\_
- Best Time to Call \_\_\_\_:\_\_\_\_  a.m.  p.m. E-mail Address (Optional) \_\_\_\_\_
- Occupation and Duties \_\_\_\_\_
- Name of Employer \_\_\_\_\_
- Annual Income \_\_\_\_\_
- Secondary Addressee Information (Optional): Please provide name and address. A copy of any notification of possible policy lapse will be sent to this person. \_\_\_\_\_  
 \_\_\_\_\_

### OWNER/APPLICANT INFORMATION (COMPLETE ONLY IF OWNER/APPLICANT IS DIFFERENT FROM PROPOSED INSURED)

- Owner's Name (if other than Proposed Insured) \_\_\_\_\_  
First Name Initial  
 \_\_\_\_\_  
Last Name or Company Name
- Tax ID Number \_\_\_\_\_ or Social Security Number \_\_\_\_\_
- Birth Date \_\_\_\_\_  Male  Female Relationship to Proposed Insured \_\_\_\_\_  
mo day yr
- Owner's Legal Address \_\_\_\_\_  
Street  
 \_\_\_\_\_  
City State ZIP
- Phone Number (\_\_\_\_) \_\_\_\_\_ E-mail Address (Optional) \_\_\_\_\_
- Are you a citizen of the United States? (If "No," list details below.) .....  Yes  No
 

Documentation	Date of Arrival in the United States
<input type="checkbox"/> Permanent Resident Card (card number _____)	/ /
<input type="checkbox"/> Visa (specify type _____)	

**SECTION B**

**OTHER PROPOSED INSURED INFORMATION**

<input type="checkbox"/> Other Proposed Insured Will Be Covered By <b>A Separate Policy</b>	<input type="checkbox"/> Other Proposed Insured Will Be Covered By <b>A Rider</b>
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**1** Other Proposed Insured \_\_\_\_\_  
First Name Initial

\_\_\_\_\_ Last Name

**2** Social Security Number \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

**3** Birth Date \_\_\_\_\_ day \_\_\_\_\_ yr \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Birth State \_\_\_\_\_  
mo

**4** Driver's License Number \_\_\_\_\_ State of Issue \_\_\_\_\_

**5** Legal Residence Address \_\_\_\_\_  
Street

\_\_\_\_\_ City State ZIP

**6** Mailing Address (if different than above) \_\_\_\_\_

**7** Relationship to Proposed Insured \_\_\_\_\_

**8** Phone Number \_\_\_\_\_ Alternate Phone Number \_\_\_\_\_

**9** Best Time To Call \_\_\_\_:\_\_\_\_  a.m.  p.m. E-mail Address (Optional) \_\_\_\_\_

**10** Occupation and Duties \_\_\_\_\_

**11** Name of Employer \_\_\_\_\_

**12** Annual Income \_\_\_\_\_

**13** Secondary Addressee Information (Optional): Please provide name and address. A copy of any notification of possible policy lapse will be sent to this person. \_\_\_\_\_

**OWNER/APPLICANT INFORMATION (COMPLETE ONLY IF OWNER/APPLICANT IS DIFFERENT FROM OTHER PROPOSED INSURED)  
 DO NOT COMPLETE THIS SECTION IF THE OTHER PROPOSED INSURED IS TO BE COVERED BY A RIDER**

**1** Owner's Name (if other than Other Proposed Insured) \_\_\_\_\_  
First Name Initial

\_\_\_\_\_ Last Name or Company Name

**2** Tax ID Number \_\_\_\_\_ or Social Security Number \_\_\_\_\_

**3** Birth Date \_\_\_\_\_ day \_\_\_\_\_ yr \_\_\_\_\_  Male  Female Relationship to Other Proposed Insured \_\_\_\_\_  
mo

**4** Owner's Legal Address \_\_\_\_\_  
Street

\_\_\_\_\_ City State ZIP

**5** Phone Number \_\_\_\_\_ E-mail Address (Optional) \_\_\_\_\_

**6** Are you a citizen of the United States? (If "No," list details below.) .....  Yes  No

Documentation	Date of Arrival in the United States
<input type="checkbox"/> Permanent Resident Card (card number _____)	/ /
<input type="checkbox"/> Visa (specify type _____)	

**SECTION C JUVENILE COVERAGE INFORMATION (COMPLETE ONLY IF PRIMARY INSURED IS A JUVENILE)**

<b>1</b>	Total Amount of life insurance in force. <b>If "None," check box below.</b>	Total Amount of Accidental Death (AD&D) insurance in force. <b>If "None," check box below.</b>
Proposed Insured	\$ _____ <b>OR</b> <input type="checkbox"/> None	\$ _____ <b>OR</b> <input type="checkbox"/> None
Name of Parent or Legal Guardian	\$ _____ <b>OR</b> <input type="checkbox"/> None	\$ _____ <b>OR</b> <input type="checkbox"/> None
Name of Parent or Legal Guardian	\$ _____ <b>OR</b> <input type="checkbox"/> None	\$ _____ <b>OR</b> <input type="checkbox"/> None

**2** Does the Proposed Insured live with the Owner/Applicant? .....  **Yes**  **No**  
**(If "No," please give details below.)**

Reason \_\_\_\_\_

Name, Address and Relationship of the person with whom the Proposed Insured is living with \_\_\_\_\_

**3** Does the Proposed Insured have any minor brothers or sisters? .....  **Yes**  **No**  
**(If "Yes," please give details below.)**

Name	Age	Total Amount of life insurance in force	If not insured, please state reason

**SECTION D UNDERWRITING INFORMATION (COMPLETE FOR PROPOSED INSURED AND OTHER PROPOSED INSURED)**

	Proposed Insured	Other Proposed Insured
	<b>Yes No</b>	<b>Yes No</b>
<b>1</b> Are the persons proposed for insurance citizens of the United States? .....	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

**(If "No," complete Foreign National Questionnaire and list details below.)**

Person Proposed for Insurance	Documentation	Date of Arrival in the United States
Proposed Insured	<input type="checkbox"/> Permanent Resident Card (card number _____) <input type="checkbox"/> Visa (specify type _____)	/ /
Other Proposed Insured	<input type="checkbox"/> Permanent Resident Card (card number _____) <input type="checkbox"/> Visa (specify type _____)	/ /

**2** Have any of the persons proposed for insurance used (a) any form of tobacco or (b) any form of nicotine replacement therapy? ..... **Yes No Yes No**

**(If "Yes," to question 2, please list details below.)**

Person Proposed for Insurance	Form of Tobacco/Nicotine Replacement Therapy	Number Per Day	Date Stopped

**IF QUESTIONS 3 THROUGH 10 ARE ANSWERED "YES," PLEASE LIST ALL APPLICABLE CONDITIONS AND DETAILS IN SECTION E ON PAGE 6 OF THIS APPLICATION.**

**3** Have any of the persons proposed for insurance ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? **Yes No Yes No**

**4** Are any of the persons proposed for insurance currently:  
**(a)** bedridden or confined to any hospital, nursing home, or other medical facility? .....      
**(b)** using any of the following: walker, wheelchair, electric scooter, oxygen or catheter? .....

**SECTION D**

**UNDERWRITING INFORMATION – CONTINUED**

	Proposed Insured		Other Proposed Insured	
	Yes	No	Yes	No
<b>5 In the past 6 months</b> , have any of the persons proposed for insurance:				
(a) required the assistance of another person, or a device of any kind for: bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) received, or been advised to have, any of the following: care in a nursing home, assisted living facility, or adult day care facility; or home health care services, or physical, occupational or speech therapy? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) applied for, received, or are you currently receiving disability, hospital or medical benefits from any insurance company, government, employer or other source other than for maternity? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6 In the past 10 years</b> , have any of the persons proposed for insurance:				
(a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a physician or other health care provider? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) been or are currently a member of Alcoholics Anonymous or Narcotics Anonymous? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>7</b> Have any of the persons proposed for insurance <b>ever</b> (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek care or treatment for, or (c) consulted with a health care provider regarding:				
(a) any disease or abnormal condition of the heart, circulatory system or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) any disease of the lungs or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema or shortness of breath? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) any digestive system disease, including ulcer, abdominal or stomach pain, liver or gallbladder disease, hepatitis, cirrhosis, colitis or other colon, intestinal or rectal disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) any urinary or reproductive system disease including protein, blood or sugar in the urine; tumor, cysts, infection or failure of the kidney; tumor or disease of the prostate, testis, breasts, uterus or ovaries? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) any brain, nerve or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) any bone or joint disorder, arthritis or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia or other bodily deformity, amputation, back or spinal disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) any disease or disorder of vision or hearing? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid or other glandular/metabolic disorder? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>8</b> If female, is the person proposed for insurance currently pregnant or has the person proposed for insurance ever had complications of pregnancy? . . . . . If currently pregnant, approximate delivery date _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>9 In the past 12 months</b> , have any of the persons proposed for insurance lost more than 10 pounds? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>10 In the past 10 years</b> , have any of the persons proposed for insurance:				
(a) had any illness, injury, surgery, hospitalization, medical examination or care not listed in Section E? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) had or received treatment for any unexplained fever, weight loss, fatigue or chronic cough? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) been advised by a physician to have a surgical operation or procedure otherwise not listed? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>11</b> Have any of the persons proposed for insurance: <b>(If answered "Yes," please list details in Section I)</b>				
(a) ever been declined, postponed, limited, denied reinstatement or asked to pay extra premium by any insurance company? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Proposed Insured		Other Proposed Insured	
	Yes	No	Yes	No
(b) engaged in any hazardous sports or activities such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, skydiving, skin diving or scuba diving, cliff diving, base jumping, or bungee jumping within the last three years, or plan such activity in the next two years? ..... <b>(If “Yes,” complete the appropriate questionnaire.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) any intention of traveling or living outside the USA or Canada in the next two years? ..... <b>(If “Yes,” complete Foreign Travel questionnaire.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) flown as a civilian pilot, student pilot or crew member within the last three years, or plan such activity in the next 12 months? ..... <b>(If “Yes,” complete Aviation Questionnaire.)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) within the last 5 years: (1) been convicted of two or more moving violations, or (2) been convicted of driving under the influence of alcohol or drugs, or (3) had a driver’s license suspended or revoked? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) within the last 10 years, been convicted of a felony? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) been on probation within the last 12 months or are currently on probation? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**12** Do any of the persons proposed for insurance currently have a personal physician? .....

**(If “Yes,” to question 12, please list details below.)**

Person Proposed for Insurance	Name, address and telephone number of personal physician	Date last seen	State reason, findings and treatment

**13** In the past 5 years, have any of the persons proposed for insurance consulted with a doctor or been hospitalized or treated for any other health condition? .....

**(If “Yes,” to question 13, please list details below.)**

Person Proposed for Insurance	Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation is performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

**14** In the past 2 years, have any of the persons proposed for insurance, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? .....

**(If “Yes,” to question 14, please list details below. If more space is needed, use Section I.)**

Person Proposed for Insurance	Medication Name (Copy From Pharmacy Label)	Date (last taken)	Prescribing Physician (if any)	Reason	Dosage / Frequency

**SECTION D UNDERWRITING INFORMATION – CONTINUED**

**15 Family History – Please list details below for both Proposed Insured and Other Proposed Insured (if applicable).**

	Age if Living		Age at Death		If Living, Present Health; If Deceased, Cause of Death	
	Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured
Father						
Mother						
Sibling 1						
Sibling 2						
Sibling 3						
Sibling 4						

**SECTION E ADDITIONAL DETAILS AND EXPLANATIONS — PROPOSED INSURED & OTHER PROPOSED INSURED**

**(Use Section I for any explanation where space is insufficient)**

Ques. No.	Person Proposed for Insurance	Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation is performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

**SECTION F PERSONAL FINANCES**

**1** What is the purpose of this insurance? (i.e., Income Replacement, Mortgage Protection, Key Person, Buy-Sell):

\_\_\_\_\_

**2** If applying for \$500,000 or more, complete Personal Finances for each person proposed for insurance.

Person Proposed for Insurance	Total Assets	Total Liabilities	Net Worth	Earned Income	Unearned Income

**3.** Has any person proposed for insurance ever filed for bankruptcy? .....  Yes  No  
 If "Yes," please provide type(s) and date(s): \_\_\_\_\_

\_\_\_\_\_

**SECTION G**

**OTHER COVERAGE AND REPLACEMENT INFORMATION**

- 1 Have you or the Insured been offered cash or any other consideration for obtaining this policy? . . . . .  Yes  No
- 2 Are you planning to enter into a finance arrangement to pay any premium payments due under this policy? . .  Yes  No  
**If “Yes,” to questions 1 or 2, provide information in Section I.**
- 3 List below all life insurance policies and/or annuity contracts on any of the Proposed Insureds that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) If none, check the following box. . . . .  None
- 4 Have any of the Proposed Insureds had, or do they intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? . . . . .  Yes  No  
**If “Yes,” to question 4, complete the appropriate box(es) below.**  
**The Producer shall comply with any additional state and/or Company replacement requirements.**

Company	Proposed Insured	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**SECTION H**

**BENEFICIARY INFORMATION**

**NOTE:** The beneficiary for an Additional Insured Rider or Other Insured Rider will be the Primary Insured unless you designate otherwise in this Section H of this application.

**Proposed Insured**

	Name	Relationship	% Share	Social Security #
Primary Beneficiary				
Primary Beneficiary				
Contingent Beneficiary				
Contingent Beneficiary				

**Other Proposed Insured**

	Name	Relationship	% Share	Social Security #
Primary Beneficiary				
Primary Beneficiary				
Contingent Beneficiary				
Contingent Beneficiary				



**PROPOSED INSURED**

Plan of Insurance \_\_\_\_\_

**Amount of Life Insurance Applied For:**

\$ \_\_\_\_\_

**Tobacco Status:**  Tobacco  Nontobacco

Risk/Rate Class Applied For:

Best Available (Risk Class Proposed \_\_\_\_\_)

**OTHER PROPOSED INSURED**

**Do not complete for Additional Insured Rider or Other Insured Rider**

Plan of Insurance \_\_\_\_\_

**Amount of Life Insurance Applied For:**

\$ \_\_\_\_\_

**Tobacco Status:**  Tobacco  Nontobacco

Risk/Rate Class Applied For:

Best Available (Risk Class Proposed \_\_\_\_\_)

**UNIVERSAL LIFE DEATH BENEFIT OPTIONS:**

Option 1: (Level) Accumulation Value Included in Specified Amount

Option 2: (Increasing) Accumulation Value in Addition to Specified Amount

**UNIVERSAL LIFE DEATH BENEFIT OPTIONS:**

Option 1: (Level) Accumulation Value Included in Specified Amount

Option 2: (Increasing) Accumulation Value in Addition to Specified Amount

**OPTIONAL RIDERS: (NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES)**

Disability Rider

Accidental Death Benefit Rider \$ \_\_\_\_\_

Guaranteed Insurability Rider \$ \_\_\_\_\_

Dependent Children's Rider \_\_\_\_\_ Units

Additional Insured Rider

Proposed Insured \$ \_\_\_\_\_

Spouse \$ \_\_\_\_\_

Other \$ \_\_\_\_\_

(Please Specify \_\_\_\_\_)

Disability Rider

Accidental Death Benefit Rider \$ \_\_\_\_\_

Guaranteed Insurability Rider \$ \_\_\_\_\_

Dependent Children's Rider \_\_\_\_\_ Units

Additional Insured Rider

Proposed Insured \$ \_\_\_\_\_

Spouse \$ \_\_\_\_\_

Other \$ \_\_\_\_\_

(Please Specify \_\_\_\_\_)

**TERM LIFE — OPTIONAL RIDERS: (NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES)**

Waiver of Premium Rider

Accidental Death Benefit Rider \$ \_\_\_\_\_

Dependent Children's Rider \_\_\_\_\_ Units

Other Insured Rider \$ \_\_\_\_\_

Waiver of Premium Rider

Accidental Death Benefit Rider \$ \_\_\_\_\_

Dependent Children's Rider \_\_\_\_\_ Units

Other Insured Rider \$ \_\_\_\_\_

**SECTION K DEPENDENT CHILDREN'S RIDER (COMPLETE ONLY IF CHILDREN ARE PROPOSED FOR INSURANCE)**

The beneficiary for the Dependent Children's Rider will be the Proposed Insured or as otherwise set forth in the rider. If more space is needed to provide Dependent Children information, attach separate sheet if necessary.

**DEPENDENT CHILDREN UNDERWRITING INFORMATION**

Have any of the Dependent Children proposed for insurance received medical care for or had:

- (a) a heart or circulatory disease? .....  Yes  No      (b) a birth defect or mental abnormality? .....  Yes  No
- (c) juvenile diabetes or any form of cancer? ....  Yes  No
- (d) any other chronic illness or condition which requires periodic medical care within the past 3 years? .....  Yes  No

**NOTE:** Provide details for "Yes" answers. Please include child's name and illness or condition. (Use additional sheet if necessary.)

---



---

**1** Child #1 \_\_\_\_\_  
First Name Initial Last Name

Age \_\_\_\_\_  Male  Female      Birth Date \_\_\_\_\_  
mo day yr

Social Security Number \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

**2** Child #2 \_\_\_\_\_  
First Name Initial Last Name

Age \_\_\_\_\_  Male  Female      Birth Date \_\_\_\_\_  
mo day yr

Social Security Number \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

**3** Child #3 \_\_\_\_\_  
First Name Initial Last Name

Age \_\_\_\_\_  Male  Female      Birth Date \_\_\_\_\_  
mo day yr

Social Security Number \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

**4** Child #4 \_\_\_\_\_  
First Name Initial Last Name

Age \_\_\_\_\_  Male  Female      Birth Date \_\_\_\_\_  
mo day yr

Social Security Number \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

**SECTION L PREMIUM AND BILLING INFORMATION**

Proposed Insured		Other Proposed Insured	
<b>1</b> Amount collected	\$ _____	<b>1</b> Amount collected	\$ _____
<b>2</b> Modal Premium	\$ _____	<b>2</b> Modal Premium	\$ _____

**(To the Producer: In order to collect money, the Premium Acceptance Guidelines and other requirements for a Temporary Life Insurance Agreement must be satisfied.)**

**3** Mode of Payment:  Annual  Semiannual  Quarterly  Monthly Bank Service Plan  PRD

**4 Complete only for PRD or Association:** Full Name of Group/Organization: \_\_\_\_\_  
 Date Joined: \_\_\_\_\_ / \_\_\_\_\_

**AUTHORIZATION TO RECEIVE INFORMATION FROM AND DISCLOSE INFORMATION TO THE MIB GROUP, INC. (“MIB”):**

The MIB Group, Inc. (“MIB”) is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

“Personal Information” means information about me, including health information such as medical history, mental and physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claim information.

To the MIB: I authorize you to disclose Personal Information about me to United of Omaha Life Insurance Company, its representatives and its reinsurers. You are not authorized to disclose Personal Information about me to a consumer reporting agency. The Personal Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance.

I also authorize United of Omaha Life Insurance Company and its reinsurers to disclose Personal Information about me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I submit a claim for benefits.

Unless revoked earlier, this authorization will remain in force for 24 months from the date below. A copy of this authorization is as effective as the original.

**AGREEMENT:**

Each of the undersigned, including the Producer(s), certify that we have read the completed application. I, the undersigned, understand and agree that:

- 1 All answers in this application are true and complete and will be relied on by United of Omaha to determine insurability. Any incorrect or misleading answers may void this application and any issued policy effective the issue date.
- 2 If mode of payment is Bank Service Plan, by signing this Life Insurance application, I/We authorize premiums due to be automatically paid to United of Omaha, by electronic fund transfer. I/We understand and agree that these authorized withdrawals for premium payments will continue until this authorization is cancelled in writing.
- 3 In order for United of Omaha to issue a policy as a result of this application: **(1)** all persons proposed for insurance must complete all required examinations and tests (medical, paramedical, laboratory), **(2)** United of Omaha must receive the reports from all required examinations and tests, and any other information (such as an Attending Physician’s Statement) that it requires, and **(3)** the application must be approved for issue by United of Omaha’s Underwriting Department. If **(1)**, **(2)** or **(3)** is not met, no policy will be issued and no coverage will be provided except by a **Temporary Insurance Agreement and Receipt**, if provided.
- 4 If the first full initial premium is paid on the date of the completed application and I am eligible for the insurance policy applied for in accordance with the underwriting standards of United of Omaha on the date the application is approved by United of Omaha’s Underwriting Department, the issue date of the policy will be the date shown in the policy. The coverage under the policy will be effective on the issue date.
- 5 If **(1)** the full initial premium **(a)** is not collected at the time this application is completed, or **(b)** will be paid by electronic funds transfer from my designated bank account after this application is approved for issue, or **(2)** the issued policy is different than the policy applied for, then coverage under the issued policy will become effective only if and when: **(a)** the full initial premium is paid or, if paid by electronic funds transfer, the full initial premium is received by United of Omaha, **(b)** there has been no change in either the health or habits of any person proposed for insurance between the date the application is approved for issue and the date the policy is delivered, and **(c)** the policy is delivered and all delivery requirements (including the execution and delivery of a good health statement and delivery receipt by the insured(s) and policyowner(s), if required) are completed and accepted during the lifetime of the proposed insured(s). The full initial premium will provide coverage from the date coverage is effective until the date the next premium is due under the policy. The issue date of the policy will be the date shown in the policy, even though coverage may not become effective until a later date.
- 6 The person proposed for insurance, or the Applicant if applicable, will immediately notify United of Omaha of any change in that person’s health or habits that will change any statement or answer to any question in the application. **If the person proposed for insurance is not eligible for the insurance applied for, I agree that no policy of any kind will be in effect except for coverage provided under the terms of the Temporary Insurance Agreement and Receipt, if issued.**
- 7 If, prior to policy delivery, any person proposed for insurance dies, or there has been a change in the health or habits of the person(s) proposed for insurance, the producer cannot deliver the policy and must return it to United of Omaha’s home office.
- 8 In no event will benefits be paid for the same loss under both a **Temporary Insurance Agreement and Receipt**, and any policy issued from this application.
- 9 I have received the MIB Group, Inc. Pre-Notice, the Notice of Information Practices, and a Life Insurance Buyer’s Guide before completing this application.
- 10 If the Applicant is other than the person proposed for insurance, the Applicant will own the policy.

– continued on next page –

- 11 No Producer can: (a) waive or change any Receipt or policy provision; or (b) agree to issue a policy.
- 12 **Fraud Warning:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**SIGNATURE(S):**

**I have read and understand the Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. (“MIB”), the Agreement Section and the Temporary Insurance Agreement and Receipt, if provided, and I approve all my answers as recorded in this application.**

Signed at: \_\_\_\_\_ Date \_\_\_\_\_  
City State mo day yr

\_\_\_\_\_  
Signature of Proposed Insured (Age 15 and over)

\_\_\_\_\_  
Signature of Applicant/Owner/Trustee (if other than Proposed Insured or if the Owner is a corporation, trust, or other entity, include title of Signee(s))

\_\_\_\_\_  
Signature of Other Proposed Insured (Age 15 and over)

\_\_\_\_\_  
Signature of Applicant/Owner/Trustee (if other than Other Proposed Insured or if the Owner is a corporation, trust, or other entity, include title of Signee(s))

\_\_\_\_\_  
Signature of Payor as shown on bank account (if Payment mode is BSP and payor is other than Proposed Insured or Other Proposed Insured)

\_\_\_\_\_  
Signature of Parent or Guardian (if Proposed Insured is under age 15)

**PRODUCER STATEMENT:**

- 1 In addition to the above Agreement, has any person proposed for insurance informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? . . . . .  Yes  No  
If “Yes,” give name(s) of the person(s) \_\_\_\_\_
- 2 Do you, the Producer(s), know or have reason to believe that the policy(ies) applied for has/have replaced, or will replace, any existing life insurance policies or annuity contracts? . . . . .  Yes  No  
If “Yes,” the Producer shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.
- 3 Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer’s Guide? . . . . .  Yes  No  
If “No,” explain. \_\_\_\_\_
- 4 In the presence of each person proposed for insurance, have you, the Producer(s), asked each question exactly as written and recorded the answers completely and accurately? . . . . .  Yes  No  
If “No,” explain. \_\_\_\_\_

\_\_\_\_\_  
Signature of Producer #1

\_\_\_\_\_  
Signature of Producer #2

\_\_\_\_\_  
Print or Stamp Producer #1 Name

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Production Number

\_\_\_\_\_  
Production Number

\_\_\_\_\_  
Print or Stamp Producer #2 Name

\_\_\_\_\_  
Agency Stamp





**PREMIUM FUNDING AND ACKNOWLEDGMENT FORM**

*Required for all applications where the proposed insured for life insurance is age 65 and above and the proposed face amount is \$1,000,000 and above. This form may also be required at the discretion of the underwriter.*

**We will screen for and reject any stranger originated life insurance (“STOLI”) policies, or policies using non-recourse premium financing. STOLI is a practice or plan to initiate a life insurance policy for the benefit of a third party who, at the time of policy origination, has no insurable interest in the life of the insured. We will consider policies funded by traditional premium financing programs:**

- **The loan must be 100% collateralized by personal or business assets of the borrower**
- **If the life insurance policy is part of the collateral, only the cash surrender value of the policy may be considered**
- **We must be provided with full details regarding all aspects of the premium financing program**
- **We reserve the right to refuse to issue the policy, based on our assessment of the premium financing structure**

Name of Owner/Applicant: \_\_\_\_\_

Name of Proposed Insured: \_\_\_\_\_

1. A. Are any funds, other than your own, intended to be used to pay the premium for any portion of the applied for life insurance?  Yes  No

If premiums are being provided by a third party, please provide the following information regarding the third party:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Owner/Applicant: \_\_\_\_\_

\_\_\_\_\_

Please submit a copy of the loan contract, agreement, term sheet, disclosure form and any other document(s) relating to or evidencing the transaction. If there is a trust involved, please provide a copy of the trust document.

- B. If you answered 1A as “Yes,” is any collateral, other than this life insurance policy required for this loan?  Yes  No

If “Yes,” please describe the collateral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Owner/Applicant understands and agrees to the following:

- Any lending institution from which you may obtain premium financing and United of Omaha Life Insurance Company operate independently from each other and are separately responsible for their respective contractual and legal obligations.
- United of Omaha Life Insurance Company is not a party to, or bound by, any of the provisions or representations relating to any premium financing arrangement related to the proposed life insured, except as may be required under any properly executed collateral assignment arrangements.
- If you finance the premium, you are solely responsible for the selection of the lender and negotiation of the terms of any loan or financing agreement.
- Premium financing may involve significant financial risks; changes in interest rates; changes in collateral valuation or requirements; or termination, modification and non-renewal of a loan, as well as other risks not listed here.
- The factors used by United of Omaha Life Insurance Company to determine your eligibility for life insurance coverage are separate and independent from those factors used by a lender to determine your eligibility for a loan.
- The terms of the life insurance policy are separate and distinct from the terms of a loan. Failure to pay sufficient premiums will result in loss of benefits under the terms of the life insurance policy.
- You agree to hold United of Omaha Life Insurance Company harmless from and against any claims, losses, liabilities, damages and expenses directly or indirectly related to any premium financing arrangement associated with the proposed life insurance policy.

*I represent that the statements and answers in this supplement and in any supporting documentation provided by me for use in conjunction with this supplement, are true and complete to the best of my knowledge and belief.*

\_\_\_\_\_  
Signature of Owner/Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured (if other than Owner/Applicant)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Date



**STATEMENT OF POLICYOWNER INTENT**

United of Omaha Life Insurance Company does not issue insurance policies unsupported by an insurable interest, including any policies involved or contemplated to be involved in stranger originated life insurance (“STOLI”) transactions. **STOLI is a practice or plan to initiate a life insurance policy for the benefit of a third party who, at the time of policy origination, has no insurable interest in the insured.**

Name of Owner/Applicant: \_\_\_\_\_

Name of Proposed Insured: \_\_\_\_\_

Questions to be answered by the owner/applicant and proposed insured (if different from owner/applicant):

1. Has the owner/applicant, proposed insured or any third party been offered any direct or indirect inducement to encourage the application for this life insurance policy, such as a cash payment, gift or loan proceeds?

Owner/Applicant             Yes             No

Proposed Insured             Yes             No

2. Is there an understanding in place or any kind of agreement that anyone other than the owner/applicant will obtain any right, title, or other legal or beneficial interest in this policy or the proceeds of this policy?

Owner/Applicant             Yes             No

Proposed Insured             Yes             No

3. Have you discussed or do you intend to discuss or otherwise communicate with anyone about the possibility of selling or otherwise using this policy or any beneficial interest in this policy or the death proceeds from this policy for any type of STOLI, life settlement, viatical settlement, senior settlement or other secondary market or similar transaction?

Owner/Applicant             Yes             No

Proposed Insured             Yes             No

Please provide an explanation for any “Yes” answers above, including identification of all parties involved.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STATEMENT OF THE OWNER/APPLICANT AND PROPOSED INSURED:**

I understand that United of Omaha Life Insurance Company does not issue insurance policies unsupported by an insurable interest, including any policies involved or contemplated to be involved in stranger originated life insurance (“STOLI”) transactions. I understand that my answers and all the other information on this statement will be relied upon by United of Omaha Life Insurance Company in deciding whether to issue this policy.

\_\_\_\_\_  
Signature of Owner/Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Insured  
(if different from the Owner/Applicant)

\_\_\_\_\_  
Date

**QUESTIONS TO BE ANSWERED BY THE PRODUCER**

1. Have you solicited, recommended, brokered, or otherwise participated in any communications with the proposed insured or the owner/applicant concerning a STOLI transaction involving this policy?  Yes  No
2. Are you aware of any intent on the part of the owner/applicant or proposed insured to sell or otherwise use this policy for any type of STOLI, life settlement, viatical settlement, senior settlement, or other secondary market or similar transaction?  Yes  No
3. Are you aware of any intent on the part of anyone other than the proposed insured or the owner/applicant to use this policy for any type of STOLI, life settlement, viatical settlement, senior settlement, or other secondary market or similar transaction?  Yes  No

Please provide an explanation for any “Yes” answers above, including identification of all parties involved.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**STATEMENT OF THE PRODUCER:**

I attest that this policy is supported by a legally recognized insurable interest. I am not aware of anyone being paid or promised any consideration in connection with the application for and/or purchase of this policy, other than compensation from United of Omaha Life Insurance Company.

I understand that my answers and all the other information on this statement will be relied upon by United of Omaha Life Insurance Company in deciding whether to issue this policy. I understand that any failure by me to provide answers that are fully truthful and correct may make me liable to return any and all compensation I may receive in connection with this policy as well as other damages. I understand that any failure by me to provide answers that are fully truthful and correct may also result in a referral to the Producer Performance Program, which could result in termination of my sales contract with United of Omaha Life Insurance Company and its affiliates.

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Date

# United of Omaha Life Insurance Company

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## Authorization To Disclose Personal Information To United of Omaha Life Insurance Company

### Meanings of Terms

**“Medical Persons and Entities” means:** all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

**“Personal Information” means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

**“Psychotherapy Notes” means:** notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

### Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to United of Omaha Life Insurance Company.

### Purposes

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

### Potential For Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

### Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

### Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting  
United of Omaha Life Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that United of Omaha Life Insurance Company has taken action in reliance on the authorization or the law allows United of Omaha Life Insurance Company to contest the issuance of the policy or a claim under the policy.

### Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

### Names and Signatures

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Spouse’s Printed Name  
(If Proposed Insured)

\_\_\_\_\_  
If children are to be insured, their printed names

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Spouse  
(If Proposed Insured)

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS**



## Accelerated Benefit Rider for Terminal and Chronic Illness Disclosure

This is a brief description of the Accelerated death benefit for Terminal and Chronic Illness rider and its effects on your policy. This is not an insurance contract, but only a summary of the coverage provided by the rider.

### TAX CONSEQUENCES

The benefits under the rider may be taxable. Receipt of the benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor of the Social Security Administration before requesting the benefit.

### BENEFIT DESCRIPTION

We will pay you a portion of the death benefit payable under the policy prior to the Insured's death if you are Chronically Ill or have a Terminal Illness. You may accelerate up to the amount specified in the rider. However, the aggregate amount you may accelerate under the rider may not exceed \$250,000.

Benefits will be paid to you under the rider if the Insured is Chronically Ill or has a Terminal Illness.

**CHRONICALLY ILL** means that a physician has certified that the Insured:

- (a) is unable to perform (without Substantial Assistance from another person) at least two Activities of Daily Living;
- and
- (b) has been confined to a Nursing Home for 90 consecutive days or more.

**TERMINAL ILLNESS** means a medical condition that, with a reasonable degree of medical certainty, will result in the Insured's death within 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

The benefit paid under the rider is an amount equal to the portion of the death benefit that you elect to accelerate less:

- (a) the discount applicable to the benefit
- (b) a charge equal to \$100.00, and
- (c) the pro rate amount of any policy loans.

### EFFECT OF BENEFIT PAYMENT ON POLICY

Upon payment of a benefit under the rider the following will occur:

- (a) If your policy includes a Return of Premium Benefit provision, the premium used to calculate the Return of Premium Benefit will be reduced by the benefit paid;
- (b) the amount of insurance coverage accumulation value and any policy loan will be reduced by the same proportion as the reduction in the death benefit ; and
- (c) the future premium and charges for the policy will be based on the reduced amount of insurance coverage.

I acknowledge receipt of this Disclosure Form.

\_\_\_\_\_  
Applicant/Owner Signature

\_\_\_\_\_  
Date

### Producer Statement (if applicable):

I have provided this Disclosure Form to the Applicant.

\_\_\_\_\_  
Producer Signature

\_\_\_\_\_  
Date



## Accelerated Benefit Rider for Terminal and Chronic Illness Disclosure

This is a brief description of the Accelerated death benefit for Terminal and Chronic Illness rider and its effects on your policy. This is not an insurance contract, but only a summary of the coverage provided by the rider.

### TAX CONSEQUENCES

The benefits under the rider may be taxable. Receipt of the benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor of the Social Security Administration before requesting the benefit.

### BENEFIT DESCRIPTION

We will pay you a portion of the death benefit payable under the policy prior to the Insured’s death if you are Chronically Ill or have a Terminal Illness. You may accelerate up to the amount specified in the rider. However, the aggregate amount you may accelerate under the rider may not exceed \$250,000.

Benefits will be paid to you under the rider if the Insured is Chronically Ill or has a Terminal Illness.

**CHRONICALLY ILL** means that a physician has certified that the Insured:

- (a) is unable to perform (without Substantial Assistance from another person) at least two Activities of Daily Living;
- and
- (b) has been confined to a Nursing Home for 90 consecutive days or more.

**TERMINAL ILLNESS** means a medical condition that, with a reasonable degree of medical certainty, will result in the Insured’s death within 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

The benefit paid under the rider is an amount equal to the portion of the death benefit that you elect to accelerate less:

- (a) the discount applicable to the benefit
- (b) a charge equal to \$100.00, and
- (c) the pro rate amount of any policy loans.

### EFFECT OF BENEFIT PAYMENT ON POLICY

Upon payment of a benefit under the rider the following will occur:

- (a) If your policy includes a Return of Premium Benefit provision, the premium used to calculate the Return of Premium Benefit will be reduced by the benefit paid;
- (b) the amount of insurance coverage accumulation value and any policy loan will be reduced by the same proportion as the reduction in the death benefit ; and
- (c) the future premium and charges for the policy will be based on the reduced amount of insurance coverage.

I acknowledge receipt of this Disclosure Form.

\_\_\_\_\_  
Applicant/Owner Signature

\_\_\_\_\_  
Date

### Producer Statement (if applicable):

I have provided this Disclosure Form to the Applicant.

\_\_\_\_\_  
Producer Signature

\_\_\_\_\_  
Date

**Producer's Report**

**(Must be completed by the Producer who obtained the application on the Proposed Primary Insured named below.)**

1 Is Proposed Primary Insured self-supporting?  Yes  No If "No," provide the following information about the person on whom Proposed Primary Insured is dependent:

Full Name \_\_\_\_\_ Address \_\_\_\_\_ Birth Date \_\_\_\_\_  
Amount of life insurance carried with all companies \$ \_\_\_\_\_ If none, state why \_\_\_\_\_

2 If Proposed Primary Insured used a different name in past, give previous different full name \_\_\_\_\_

3 (a) Are you related to the Proposed Primary Insured or Owner?  Yes  No If "Yes," state relationship \_\_\_\_\_

(b) How long have you known the Proposed Primary Insured? \_\_\_\_\_

(c) How long have you known the Proposed Owner? \_\_\_\_\_

4 When did you last see the Proposed Primary Insured? \_\_\_\_\_

5 Do you have any information not presented in this application which might in any way affect the issuance of this policy? (if "Yes," explain below)?  Yes  No

\_\_\_\_\_

6 Proposed Primary Insured's Household Annual Income \$ \_\_\_\_\_ Exact / Estimated (Circle One)

7 What is the purpose of this insurance? Give details including financial information (for life insurance amounts of \$500,000 or more, financial statements may be requested) \_\_\_\_\_

8 Is a paramed exam to be completed?  Yes  No (b) Name of examiner or paramedical facility \_\_\_\_\_

9 Previous residence(s) of Proposed Primary Insured for past five years.

Address	From	To

**Details**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Division Office/Brokerage General Agency/Bank Information**

Printed Name of Producer/Production No. _____	Printed Name of Producer/Production No. _____
Commission % Share _____	Commission % Share _____
Phone No. _____	Phone No. _____
E-Mail Address _____	E-Mail Address _____
Date _____	Date _____

Reviewed By: \_\_\_\_\_  
(Division Office, BGA, Bank Name)

\_\_\_\_\_  
(DSM, Assistant Wholesaler or Authorized Reviewer's Printed Name)

Agency Stamp

DSM Stamp

## **United of Omaha Life Insurance Company – MIB Group, Inc. Pre-Notice**

Information regarding your insurability will be treated as confidential. United of Omaha Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information is: 50 Braintree Hill Park, Suite 400, MA 02184-8734.

United of Omaha 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](http://www.mib.com).

## **Fair Credit Reporting Act Disclosure Statement**

Mutual of Omaha Insurance Company and/or United of Omaha Life Insurance Company, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights under Section 609 (c) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address: Attention: Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, Nebraska 68175.

## **United of Omaha Life Insurance – Notice of Information Practices**

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.**

## **Investigative Consumer Reports Notice**

United of Omaha Life Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

**GIVE THIS NOTICE TO THE APPLICANT**

## A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to [www.ftc.gov/credit](http://www.ftc.gov/credit) or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.ftc.gov/credit](http://www.ftc.gov/credit).

**GIVE THIS COPY TO APPLICANT**

- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit [www.ftc.gov/credit](http://www.ftc.gov/credit).

**States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:**

**TYPE OF BUSINESS:**

Consumer reporting agencies, creditors and others not listed below

National banks, federal branches/agencies of foreign banks (word “National” or initials “N.A.” appear in or after bank’s name)

Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)

Savings associations and federally chartered savings banks (word “Federal” or initials “F.S.B.” appear in federal institution’s name)

Federal credit unions (words “Federal Credit Union” appear in institution’s name)

State-chartered banks that are not members of the Federal Reserve System

Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission

Activities subject to the Packers and Stockyards Act, 1921

**CONTACT:**

Federal Trade Commission: Consumer Response Center - FCRA  
Washington, DC 20580  
1-877-382-4357

Office of the Comptroller of the Currency  
Compliance Management, Mail Stop 6-6  
Washington, DC 20219  
800-613-6743

Federal Reserve Board  
Division of Consumer & Community Affairs  
Washington, DC 20551  
1-202-452-3693

Office of Thrift Supervision  
Consumer Complaints  
Washington, DC 20552  
1-800-842-6929

National Credit Union Administration  
1775 Duke Street  
Alexandria, VA 22314  
1-703-519-4600

Federal Deposit Insurance Corporation  
Consumer Response Center, 2345 Grand Avenue, Suite 100  
Kansas City, Missouri 64108-2638  
1-877-275-3342

Department of Transportation , Office of Financial Management  
Washington, DC 20590  
1-202-366-1306

Department of Agriculture  
Office of Deputy Administrator - GIPSA  
Washington, DC 20250  
1-202-720-7051

# Temporary Life Insurance Agreement and Receipt ("Agreement")

United of Omaha Life Insurance Company ("United," "We," "Our," "Us"), Mutual of Omaha Plaza, Omaha, NE 68175

**\*\*THIS AGREEMENT MUST BE RETURNED WITH THE APPLICATION TO THE HOME OFFICE.**

## FACE AMOUNT REQUIREMENTS:

- Total amount of insurance applied for cannot exceed \$500,000.
- If the total amount of insurance applied for exceeds \$500,000, **NO MONEY** can be collected and no coverage will be in effect under this Agreement.

## HEALTH QUESTION REQUIREMENT:

- If a question below is answered "Yes," **NO MONEY** can be collected and no coverage is in effect under this Agreement.

## PAYMENT REQUIREMENT:

- Payment must be made by check; no credit cards or cash.
- Checks must be made out to United of Omaha.**
- Do not make checks out to the Producer.**
- The full initial premium must be provided (2 months for BSP).
- The Agreement and premium must be submitted with the application. The Agreement and/or premium cannot be submitted at a later date.

**If any of the questions listed below are answered "Yes" or not answered, no Producer of United is authorized to complete this Agreement, or accept money with the application, and no coverage will take effect under this Agreement.**

	YES	NO
1 Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, had surgery performed or recommended, or been advised to have a diagnostic test other than an HIV test? .....	<input type="checkbox"/>	<input type="checkbox"/>
2 Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider? .....	<input type="checkbox"/>	<input type="checkbox"/>
3 Has any Proposed Insured ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or been treated for or had treatment recommended for AIDS or ARC by a physician or other health care provider?.....	<input type="checkbox"/>	<input type="checkbox"/>
4 Is any Proposed Insured under 15 days old or over 70 years of age? .....	<input type="checkbox"/>	<input type="checkbox"/>

No money was collected with the application on \_\_\_\_\_ and this Temporary Insurance Agreement is not in effect.  
Proposed Insured(s)

Producers' Signature(s): \_\_\_\_\_ Date \_\_\_\_\_ (STOP. DO NOT CONTINUE.)

In consideration of the application and payment of \$ \_\_\_\_\_ by the Applicant, receipt of which is hereby acknowledged, United agrees to provide temporary life insurance for the Proposed Insured(s) effective on the date of the application, for a limited period of time, subject to the following conditions and limitations.

- A** If the correct answer to any of the above questions is "Yes," or the answer given above is incorrect or misleading, or if any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.
- B** Temporary life insurance under this Agreement will automatically terminate on the earliest of the following dates:
  - (1) 90 days from the date of this Agreement, except in Connecticut; or
  - (2) the date that insurance takes effect under the policy applied for; or
  - (3) the date of the letter offering to the Applicant a policy, other than applied for; or
  - (4) the date a policy, other than as applied for, is offered by a Producer to the Applicant; or
  - (5) the date the premium refund is mailed; or
  - (6) the date any check or draft submitted as payment is not honored by the bank on which it is drawn; or
  - (7) the date United mails notice of termination of coverage.
- C** If the policy applied for is either (a) pursuant to a conversion privilege in (an) existing United life policy(ies), or (b) to replace (an) existing United life policy(ies) with another United life policy, then in the event of the death of the Proposed Insured before the termination of this Agreement, United will pay only the greater of:
  - (1) the benefits due under the terms of the existing policy(ies) which is/are being converted or replaced, or
  - (2) the benefits due under the terms of this Agreement.The Applicant acknowledges and agrees that benefits shall not be payable under both, C.(1) and C.(2) above.
- D** The temporary life insurance provided by this Agreement is subject to the provisions of the policy form applied for; however, no benefits will be paid for:
  - (1) disability; or
  - (2) death from suicide while sane or insane (in Missouri, only if suicide was intended at the time of this application and we can prove it was intended); or
  - (3) the same loss under both this Agreement and any life policy issued from the application.

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement limit or waive any rights under any life insurance policy issued. If the application is rejected by United, the amount paid with the application will be refunded to the Applicant regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer.

**If any Proposed Insured meets the terms of this Agreement and dies prior to the termination of this Agreement, United will pay the beneficiary the face amount applied for (unless otherwise required by C above), not to exceed \$500,000.**

I have read and received a copy of this Agreement and understand and agree to all of its terms. I verify the above answers are true and complete.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Printed Name of Proposed Insured \_\_\_\_\_

Signature of Proposed Insured \_\_\_\_\_

Printed Name of Applicant (if other than Proposed Insured) \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Printed Name of Spouse (if a Proposed Insured) \_\_\_\_\_

Signature of Spouse \_\_\_\_\_

Printed Name of Producer(s) \_\_\_\_\_

Signature of Producer(s) \_\_\_\_\_

8474L-0703

# Temporary Life Insurance Agreement and Receipt ("Agreement")

United of Omaha Life Insurance Company ("United," "We," "Our," "Us"), Mutual of Omaha Plaza, Omaha, NE 68175

**\*\*APPLICANT'S COPY\*\* LEAVE WITH THE APPLICANT ONLY IF ALL REQUIREMENTS OF THIS AGREEMENT ARE MET AND MONEY IS COLLECTED.**

**FACE AMOUNT REQUIREMENTS:**

- Total amount of insurance applied for cannot exceed \$500,000.
- If the total amount of insurance applied for exceeds \$500,000, **NO MONEY** can be collected and no coverage will be in effect under this Agreement.

**HEALTH QUESTION REQUIREMENT:**

- If a question below is answered "Yes," **NO MONEY** can be collected and no coverage is in effect under this Agreement.

**PAYMENT REQUIREMENT:**

Payment must be made by check; no credit cards or cash. **Checks must be made out to United of Omaha. Do not make checks out to the Producer.** The full initial premium must be provided (2 months for BSP). The Agreement and premium must be submitted with the application. The Agreement and/or premium cannot be submitted at a later date.

**If any of the questions listed below are answered "Yes" or not answered, no Producer of United is authorized to complete this Agreement, or accept money with the application, and no coverage will take effect under this Agreement.**

	YES	NO
1 Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, had surgery performed or recommended, or been advised to have a diagnostic test other than an HIV test? .....	<input type="checkbox"/>	<input type="checkbox"/>
2 Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider? .....	<input type="checkbox"/>	<input type="checkbox"/>
3 Has any Proposed Insured ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or been treated for or had treatment recommended for AIDS or ARC by a physician or other health care provider?.....	<input type="checkbox"/>	<input type="checkbox"/>
4 Is any Proposed Insured under 15 days old or over 70 years of age? .....	<input type="checkbox"/>	<input type="checkbox"/>

**No money was collected with the application on \_\_\_\_\_ and this Temporary Insurance Agreement is not in effect.**  
Proposed Insured(s)

**Producers' Signature(s): \_\_\_\_\_ Date \_\_\_\_\_ (STOP. DO NOT CONTINUE.)**

In consideration of the application and payment of \$ \_\_\_\_\_ by the Applicant, receipt of which is hereby acknowledged, United agrees to provide temporary life insurance for the Proposed Insured(s) effective on the date of the application, for a limited period of time, subject to the following conditions and limitations.

- A** If the correct answer to any of the above questions is "Yes," or the answer given above is incorrect or misleading, or if any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.
- B** Temporary life insurance under this Agreement will automatically terminate on the earliest of the following dates:
  - (1) 90 days from the date of this Agreement, except in Connecticut; or
  - (2) the date that insurance takes effect under the policy applied for; or
  - (3) the date of the letter offering to the Applicant a policy, other than applied for; or
  - (4) the date a policy, other than as applied for, is offered by an Producer to the Applicant; or
  - (5) the date the premium refund is mailed; or
  - (6) the date any check or draft submitted as payment is not honored by the bank on which it is drawn; or
  - (7) the date United mails notice of termination of coverage.
- C** If the policy applied for is either (a) pursuant to a conversion privilege in (an) existing United life policy(ies), or (b) to replace (an) existing United life policy(ies) with another United life policy, then in the event of the death of the Proposed Insured before the termination of this Agreement, United will pay only the greater of:
  - (1) the benefits due under the terms of the existing policy(ies) which is/are being converted or replaced, or
  - (2) the benefits due under the terms of this Agreement.
 The Applicant acknowledges and agrees that benefits shall not be payable under both, C.(1) and C.(2) above.
- D** The temporary life insurance provided by this Agreement is subject to the provisions of the policy form applied for; however, no benefits will be paid for:
  - (1) disability; or
  - (2) death from suicide while sane or insane (in Missouri, only if suicide was intended at the time of this application and we can prove it was intended); or
  - (3) the same loss under both this Agreement and any life policy issued from the application.

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement limit or waive any rights under any life insurance policy issued. If the application is rejected by United, the amount paid with the application will be refunded to the Applicant regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Producer.  
**If any Proposed Insured meets the terms of this Agreement and dies prior to the termination of this Agreement, United will pay the beneficiary the face amount applied for (unless otherwise required by C above), not to exceed \$500,000.**

I have read and received a copy of this Agreement and understand and agree to all of its terms. I verify the above answers are true and complete.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Printed Name of Proposed Insured	Signature of Proposed Insured
Printed Name of Applicant (if other than Proposed Insured)	Signature of Applicant
Printed Name of Spouse (if a Proposed Insured)	Signature of Spouse
Printed Name of Producer(s)	Signature of Producer(s)

# Notice and Consent for HIV-Related Testing

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Mutual of Omaha Insurance Company  
United of Omaha Life Insurance Company  
United World Life Insurance Company

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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 changes 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 result 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 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.

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Mutual of Omaha Insurance Company  
United of Omaha Life Insurance Company  
United World Life Insurance Company

- ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
- ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

**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 that 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.

Name of physician for reporting a possible positive test result \_\_\_\_\_

Address \_\_\_\_\_

In the event that the test is positive and you are denied coverage because of that fact, and 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 collection of a sample 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 result 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.

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name of Proposed Insured

\_\_\_\_\_  
Address

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Mutual of Omaha Insurance Company  
United of Omaha Life Insurance Company  
United World Life Insurance Company

- ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
- ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

### 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 that 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.

Name of physician for reporting a possible positive test result \_\_\_\_\_

Address \_\_\_\_\_

In the event that the test is positive and you are denied coverage because of that fact, and 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 collection of a sample 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 result 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.

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name of Proposed Insured

\_\_\_\_\_  
Address

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

## Acknowledgment Form

<b>Name of Proposed Insured:</b> <b>Age</b> <b>Sex</b>	<b>Name of Applicant (if other than Proposed Insured):</b>
<b>Address of Proposed Insured:</b>	<b>Address of Applicant (if other than Proposed Insured):</b>
<b>City:</b> <b>State:</b> <b>ZIP:</b>	<b>City:</b> <b>State:</b> <b>ZIP:</b>

I, the Producer, hereby certify that (check only one):

- no illustration was used in the sale of the life insurance policy applied for;
- OR
- the life insurance policy applied for is other than as shown in the policy illustration.

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Date

I, the applicant/owner, acknowledge that (check only one):

- no policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered;
- OR
- the policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Applicant/Owner  
(if other than Proposed Insured)

\_\_\_\_\_  
Date

Submit This Copy To The Company

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

## Acknowledgment Form

<b>Name of Proposed Insured:</b> <b>Age</b> <b>Sex</b>	<b>Name of Applicant (if other than Proposed Insured):</b>
<b>Address of Proposed Insured:</b>	<b>Address of Applicant (if other than Proposed Insured):</b>
<b>City:</b> <b>State:</b> <b>ZIP:</b>	<b>City:</b> <b>State:</b> <b>ZIP:</b>

I, the Producer, hereby certify that (check only one):

- no illustration was used in the sale of the life insurance policy applied for;
- OR
- the life insurance policy applied for is other than as shown in the policy illustration.

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Date

I, the applicant/owner, acknowledge that (check only one):

- no policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered;
- OR
- the policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Applicant/Owner  
(if other than Proposed Insured)

\_\_\_\_\_  
Date

Give This Copy To The Applicant/Owner

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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## Certification

I certify that I displayed a computer screen illustration for \_\_\_\_\_  
that complies with state requirements and for which no hard copy was furnished. The  
illustration was based on the following personal and policy information:

1. Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
2. Age:	_____	
3. Risk Class / Rating Class:	_____ / _____	
4. Type of Policy:	_____	
5. Initial Death Benefit:	_____	

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Date

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

\_\_\_\_\_  
Signature of Applicant/Owner

\_\_\_\_\_  
Date

Submit This Copy To The Company

# UNITED OF OMAHA LIFE INSURANCE COMPANY

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## Certification

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2. Age:	_____	
3. Risk Class / Rating Class:	_____ / _____	
4. Type of Policy:	_____	
5. Initial Death Benefit:	_____	

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Date

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\_\_\_\_\_  
Signature of Applicant/Owner

\_\_\_\_\_  
Date

Submit This Copy To The Applicant/Owner

# UNITED OF OMAHA LIFE INSURANCE COMPANY

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## Fixed Life Replacement Sales Material Checklist

Required for all Fixed Life replacement sales.

Applicant Name: \_\_\_\_\_

Producer Name: \_\_\_\_\_ Date: \_\_\_\_\_

For all Fixed Life replacement sales, please enter the form's series number in the "Form Number –" Column and place a check mark in the "Check Box" Column next to each piece of sales material which was presented to the applicant. Copies of these materials must also be left with the applicant at the time the application is completed. Electronically presented sales material must be provided to the policyowner in printed form not later than at the time of policy delivery.

Item	Description	Form Number – list series # if applicable	Check Box
Life Financial Report	Brochure	MLC25961_	
Life Product Line	Brochure	LC4227_	
Life Time Protection	Brochure	LC1975_	
Legacy SPL	Brochure	LC5576_	
Legacy SPL	Highlight Sheet	LC5575_	
Term Life Express 15, 30	Brochure	LC5959_	
Term Life Express 15, 30	Highlight Sheet	LC5960_	
Term Life Express 15, 20, 30	Brochure	LC6587	
Term Life Express 15, 20, 30	Highlight Sheet	LC6588_BW	
Term Life Complete 15, 30	Brochure	LC5962_	
Term Life Complete 15, 30	Highlight Sheet	LC5963_	
Term Life Complete 15, 20, 30	Brochure	LC6815	
Term Life Complete 15, 20, 30	Highlight Sheet	LC6813_BW	
Mortgage Term Plus	Brochure	LC5494_	
Mortgage Term Plus	Highlight Sheet	LC5493_	
Priority AccumUL	Highlight Sheet	LC4884_	
Priority AccumUL	Brochure	LC4961	
Guaranteed Universal Life Express & Complete	Brochure	LC6217_	
Guaranteed Universal Life Express	Highlight Sheet	LC6354_	
Guaranteed Universal Life Complete	Highlight Sheet	LC6353_	
Priority Max GUL	Highlight Sheet	LC4721_	
Term Life 10, 15, 20 & 30	Highlight Sheet	LC6452_	
<b>*All Other Materials Used:</b> Please list item, description and form number (if any),			

\*NOTE: Copies of materials listed in the "All Other Materials Used" section must be attached to this document.

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# UNITED OF OMAHA LIFE INSURANCE COMPANY

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## Replacement of Life Insurance or Annuities

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

### PREMIUMS:

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- Are they affordable?
- Could they change?
- You're older—are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

### POLICY VALUES:

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- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

### INSURABILITY:

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- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

### IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

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- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

### IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

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- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

### OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

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- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

**Notice:** You have the right to return the policy within 30 days of delivery and receive an unconditional full refund of all premiums or considerations paid on it including any policy fees or charges. In the case of a variable or market value adjustment policy, you will receive the cash surrender value plus any fees or other charges deducted from the gross premiums or considerations.

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

## Important Notice: Replacement of Life Insurance or Annuities

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? .....  YES  NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? .....  YES  NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

Insurer Name	Contract or Policy #	Insured	Replaced (R) or Financing (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_

I certify that the responses herein are, to the best of my knowledge are accurate.

Applicant	Applicant B (if applicable)
Printed Name of Proposed Applicant/Owner	Printed Name of Proposed Applicant/Owner
Signature of Proposed Applicant/Owner	Signature of Proposed Applicant/Owner
Date	Date

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Printed Name/Date

I do not want this notice read aloud to me. \_\_\_\_\_ (Applicants must initial only if they do not want the notice read aloud.)

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Signature of Proposed Applicant/Owner	Signature of Proposed Applicant/Owner
Date	Date

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Printed Name/Date

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