Guaranteed Universal Life Express & Guaranteed Universal Life Complete

Application Submission Checklist (Please submit with application)

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

☐ **Application**

1. Answer all questions completely and legibly.
2. Be sure the application is signed and dated in all places indicated by the Proposed Insured(s) and the applicant if other than the Proposed Insured.
3. Any changes should be initialed by the Proposed Insured(s) and, if applicable, the Applicant.
4. Use age last birthday.
5. See reverse side of this page for additional detailed information.

☐ **Have Client sign 'Authorization to Disclose Personal Information' (HIPAA Authorization) and submit with application.**

☐ **Complete and submit 'Producer's Report'**

☐ **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**

☐ **Collect Premium Amount — See the Guidelines on the reverse side for premium acceptance requirements.**

1. Full modal premium is to be collected at the time of application.
2. If the Bank Service Plan (BSP) is selected, complete the BSP authorization and collect two (2) months premium.

☐ **Temporary Life Insurance Agreement (TIA) Reminders**

1. **No money collected —** The Producer is required to sign and date the Temporary Insurance Agreement when no money can be collected.
2. **Money collected —** If money can be collected, the Temporary Insurance Agreement must be completed, dated and signed by the Producer and the Proposed Insured(s).

☐ **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**

☐ **Have Client sign 'Accelerated Death Benefit for Terminal and Chronic Illness Rider Disclosure' and provide copy to client**

☐ **Have Client sign any state specific forms, including HIV Consent Form, 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 copy of the Cover Letter (if appropriate)**

☐ **Attach copy of the proposal illustration (if available)**

☐ **Complete the Oral Fluid Test or schedule Paramed examination, as applicable**
APPS 1-800-635-1677 PORTAMEDIC 1-800-765-1010

☐ **Comments, Additional Information, Cover Memo Information ... please list**

____

____

____

Section 2

☐ **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.

There are three parts to this application: 1) general application, 2) supplement to application and 3) necessary administrative forms that you will need at time of sale.

☐ APPLICATION - Complete for all applicants

Section A: General Information

- Please provide complete name, address, and Social Security Number. Answer all other questions in this section in full.

Section B: Dependent Children's Rider

- Complete all information if applying for the Dependent Children's Rider

Sections C1 and C2 Underwriting Information

- Complete Section C1 for all applicants
- Complete Section C2 only if applying for Guaranteed Universal Life Express

Section D: Other Coverage Information

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

Section E: Beneficiary and Plan Information

- Complete all Beneficiary information including relationship and Social Security Number.
- Select product type based on the following product criteria:

Guaranteed Universal Life Express	
Face amounts of $50,000 - $250,00 Standard Non-Tobacco Standard Tobacco Risk Classes Simplified Underwriting (Std. - through table 4)	
Guaranteed Universal Life Complete	**Guaranteed Universal Life Complete**
Face amounts of $50,000 - $99,999 Ages 66-85 Standard Non-Tobacco Standard Tobacco Full Underwriting	Face amounts of $100,000 - Plus Preferred Plus Non-Tobacco/ Preferred Non-Tobacco, Standard Plus Non-Tobacco/ Standard Non-Tobacco, Standard Plus Tobacco, Standard Tobacco and Standard (Table Rated) Full Underwriting

- Select any optional riders to be applied

Section F: Disability Rider

- Complete all information if applying for the Disability Rider.

Sections G: Premium and Billing Information

- Complete all information including amount collected (if applicable) and Modal Premium.

Section H: Please Read and Sign

- Please request the applicant read the entire Agreement section before signing.
- All proposed insureds need to sign this section.
- Any alterations to this section will not be accepted.

☐ SUPPLEMENT TO APPLICATION - Complete only if applying for Guaranteed Universal Life Complete

Sections A, B and C:

- Complete all information for all applicants

Sections D and E:

- Provide additional information to the application only if applicable.

Section F: Please Read and Sign

- Please request the applicant read the entire section before signing.
- All proposed insureds need to sign this section.
- Any alterations to this section will not be accepted.

☐ ADMINISTRATIVE FORMS

Privacy Authorization

- The "Authorization to Disclose Personal Information" (HIPAA) is to be signed and returned with the application.

Notices (MIB Group, Inc. Pre-Notice, Notice of Information Practices and Investigative Consumer Reports Notice)

- Remove notices and give to proposed insured at time of application. The MIB Group, Inc. Pre-Notice describes the MIB Group, Inc., the services it provides to members, and the Proposed Insured's right to request the MIB Group, Inc. to arrange disclosure in accordance with procedures set forth in the Fair Credit Reporting Act. The Notice of Information Practices informs the Proposed Insured that United of Omaha may obtain information about the Proposed Insured from other sources. The Investigative Consumer Reports Notice informs the Proposed Insured that United of Omaha may obtain information about the Proposed Insured through personal interviews.

Temporary Life Insurance Agreement and Receipt

Do Not Collect Premium If:	**Collect Premium If:**
☐The total amount of life insurance applied for is greater than $500,000; or	☐The total amount of insurance applied for does not exceed $500,000; and
☐The answer to any of the four questions on the TIA is "Yes."	☐All four questions on the TIA are answered "No"
If no premium is collected then:	**If premium is collected then:**
1 Check the box on the TIA form in the middle of the form indicating no money was collected	**1** Complete the TIA form
2 Insert the name(s) of the Proposed Insured(s)	**2** Insert the date
3 Sign the TIA on the Producers' Signature line in the middle of the form and insert the date	**3** Obtain the client(s) signature(s)
4 Do Not have the client(s) sign the TIA*	**4** Leave one copy of the completed TIA form with the client
5 Submit both copies of the TIA to the Home Office with the Application	**5** Submit the second copy of the TIA to the Home Office with the Application

* 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 client(s) to evidence that a TIA has not been provided. Both copies of the TIA must be submitted to the Home Office with the application.

Accelerated Death Benefit Rider Disclosure Form

- Sign and detach copy to leave with applicant.

State Specific Forms, including HIV Consent Form — complete if applicable

- Be sure to include all state appropriate forms.

Replacement Notice — complete if applicable

- Complete and leave a copy with the applicant (if applicable).

Application for Life Insurance

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

☐ ADULT LIFE
☐ New Business
☐ Replacement or Rate Reconsideration
☐ Term Conversion
☐ Addition to Existing Policy #__________

Mutual of Omaha

Section A PROPOSED INSURED INFORMATION

Use Black or Blue Ink and all Capital Letters

1 Proposed Insured First Initial
Last

2 Social Security Number Age _______ Male Female

3 Birth Date MM DD YY Height ________ Weight ________ Birth State

4 Legal Residence Address Street
City State ZIP

5 Mailing Address ____________________

6 Phone No. Alternate Phone No.

7 Best Time To Call _____:_____ ☐ AM ☐ PM E-mail Address (Optional) ____________________

8 Occupation and Duties ____________________ Name of Employer ____________________

9 Annual Income ____________________ Driver's License Number/State of Issue ____________________

10 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)

1 Owner's Name (if other than Proposed Insured) First Initial
Last or Company Name

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

3 Birth Date MM DD YY Male Female Relationship to Proposed Insured ____________________

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

Documentation	Date of Arrival in the United States
☐ Permanent Resident Card (card number ____________________) ☐ Visa (specify type ____________________)	/ /

Section B DEPENDENT CHILDREN'S RIDER (Complete only if applying for Dependent Children's Rider)

Dependent Children Information

Child	Name (First, Initial, Last)	Age	Sex	Birth Date	Social Security Number	Relationship to Proposed Insured
1			☐ Male ☐ Female			
2			☐ Male ☐ Female			
3			☐ Male ☐ Female			

If more space is needed to provide Dependent Children information, attach separate sheet if necessary.

Dependent Children Underwriting Information

Have any of the Proposed Insureds received medical care for or had:

(a) a heart or circulatory disease? ☐ **Yes** ☐ **No** **(b)** a birth defect or mental abnormality? ☐ **Yes** ☐ **No**

(c) 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.)

____

____

____

____

____

____

Section C1 UNDERWRITING INFORMATION (Complete for all applicants)

		Proposed Insured Yes	No
1	Has the person 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?	☐	☐
2	Is the person 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?	☐	☐
3	**In the past 6 months**, has the person proposed for insurance:		
	(a) required the assistance of another person, or a device or any kind for: bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems?	☐	☐
	(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?	☐	☐
4	**In the past 5 years**, has the person proposed for insurance used (a) any form of tobacco or (b) any form of nicotine replacement therapy?	☐	☐

(If "Yes," to question 4, please list details below.)

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

		Yes	No
5	Is the person proposed for insurance a citizen of the United States?	☐	☐

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

Person Proposed for Insurance	Documentation	Date of Arrival in the United States
Proposed Insured	☐ Permanent Resident Card (card number ____________) ☐ Visa (specify type ____________)	/ /

IF APPLYING FOR EXPRESS ISSUE COMPLETE SECTION C2
IF APPLYING FOR A FULLY UNDERWRITTEN PRODUCT PROCEED TO SECTION D AND COMPLETE THE ATTACHED SUPPLEMENTAL APPLICATION.

Section C2 ADDITIONAL UNDERWRITING INFORMATION (Complete if applying for Express issue coverage)

IF THE PERSON PROPOSED FOR INSURANCE ANSWERS "YES" TO ANY QUESTIONS IN SECTION C2, THAT PERSON IS NOT ELIGIBLE FOR THE EXPRESS COVERAGE. HOWEVER, THAT PERSON MAY STILL QUALIFY FOR THE FULLY UNDERWRITTEN COMPLETE PRODUCT.

	Proposed Insured
1 Has the person proposed for insurance **ever** (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for, or (c) consulted with a health care provider regarding:	**Yes** **No**
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease or Replacement, Cardiomyopathy, Congenital Heart Disease, Stroke, or Cerebral or Symptomatic Aneurysm?	☐ ☐
(b) Chronic Lung Disease (except mild Asthma), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis?	☐ ☐
(c) Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Demyelinating Disease including Multiple Sclerosis; Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down's Syndrome or any other disease of the central nervous system?	☐ ☐
(d) Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Hepatitis B or Hepatitis C?	☐ ☐
(e) Diabetes with onset before age 50 or with vascular or renal complications?	☐ ☐
(f) Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell skin cancer)?	☐ ☐
2 **In the past 10 years**, has the person proposed for insurance:	
(a) been treated or advised to be treated for alcoholism, alcohol use, or any drug/substance use?	☐ ☐
(b) been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had 4 or more moving violations?	☐ ☐
(c) been convicted of a felony?	☐ ☐
(d) been hospitalized for high blood pressure or any mental or nervous disorder?	☐ ☐
3 **In the next 2 years**, will the person proposed for insurance engage in any hazardous sports or activities such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, or skydiving?	☐ ☐
4 **In the past 12 months**, has the person proposed for insurance been advised by a physician to have a surgical operation, diagnostic testing, treatment, or other procedure which has not been done?	☐ ☐
5 **In the past 12 months**, has the person proposed for insurance consulted a physician for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding?	☐ ☐

Section D OTHER COVERAGE AND REPLACEMENT INFORMATION

1. 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**
2. 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," 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?
				☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
				☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Section E — BENEFICIARY AND PLAN INFORMATION

Beneficiary Information

Primary Beneficiary Name: ______________________

Relationship: ______________________

Social Security Number: ______________________

Contingent Beneficiary Name: ______________________

Relationship: ______________________

Social Security Number: ______________________

Plan Information - Universal Life

UNIVERSAL LIFE

Face Amount of Coverage $ ______________________ Plan of Insurance: ______________________

Risk/Rate Class Applied For: ______________________

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

Section F — COMPLETE IF APPLYING FOR THE DISABILITY RIDER

If the person proposed for insurance answers "Yes" to any of the questions 1(a) through 3 below, that person is not eligible for this Rider.		Proposed Insured	
		Yes	**No**
1	**In the past 10 years,** has the person proposed for insurance ever (a) received care or treatment for, or (b) been diagnosed by a physician or health care provider as having:		
	(a) Fibromyalgia, Chronic Fatigue Syndrome, Chronic Epstein-Barr, Rheumatoid Arthritis or other inflammatory arthritis?..............	☐	☐
	(b) Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder?..............	☐	☐
	(c) Disease or disorder of the spinal column, neck or back, including acute and chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, and congenital disorders of the spinal column and back?..............	☐	☐
	(d) **Any** Mental or Nervous System Disorder (including Grand Mal Epilepsy)?..............	☐	☐
2	**In the past 12 months,** has the person proposed for insurance regularly taken prescription medication(s) (e.g. Darvon/propoxyphene, narcotic or codeine derivative) for three consecutive months or more for the control of chronic pain?..............	☐	☐
3	**In the past 6 months**, has the person proposed for insurance applied for, received, or are you currently receiving disability benefits from any insurance company, government, employer or other source other than for maternity?	☐	☐
4	Are you currently engaged in your occupation on an active full-time basis (30 hours or more per week)?	☐	☐
5	What is the monthly amount of any other disability insurance you have in force?..............	$_______	

Section G PREMIUM AND BILLING INFORMATION

1 Amount collected $ ____________________ **2** 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 **Complete only for PRD or Association or Franchise Coverage:**

Full Name of Group/Organization: ____________________

Date Joined: ______ / ________

4 Mode of Payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ Monthly Bank Service Plan (select one below) ☐ PRD

AUTHORIZATION TO WITHDRAW FUNDS BY UNITED OF OMAHA LIFE INSURANCE COMPANY ("United of Omaha")

(If Mode of Payment is Monthly BSP - select one below)

☐ Monthly Bank Service Plan **(initial premium collected with the application)** — I/We have paid the initial premium by check to United of Omaha.

☐ Monthly Bank Service Plan **(initial premium paid by electronic funds transfer)**— I/We authorize the initial premium for the policy(ies) to be paid to United of Omaha, by electronic funds transfer, from the bank account identified below. The withdrawal for the initial premium payment will occur only if and when the application(s) is/are approved for issue by United of Omaha.

I/We authorize renewal premiums to be automatically paid to United of Omaha, by electronic fund transfer, from the bank account identified below and on the date specified below. I/We understand and agree that these authorized withdrawals from the bank account for premium payments will continue until this authorization is cancelled in writing.

If Monthly Bank Service Plan complete information below **OR** attach a voided check:

Routing Number and Transit Number (9-digit number.) ____________________

Account Number ____________________

Name of Payor as shown on account ____________________
First Initial **Last**

Social Security Number of Payor ________— ______— ________

Specify the date renewal premiums will be withdrawn (1st through the 28th of each month) ________

Section H PLEASE READ AND SIGN

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, which includes the Supplement to Application for Life Insurance, if completed, 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. 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.
3. 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 will be the date of Underwriting approval or the expiration date of any replaced coverage, if later. Coverage under the policy will be effective on the issue date.
4. 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.
5. 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.**
6. 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.
7. 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.
8. 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.
9. If the Applicant is other than the person proposed for insurance, the Applicant will own the policy.
10. No Producer can: **(a)** waive or change any Receipt or policy provision; or **(b)** agree to issue a policy.
11. **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.

continued on next page

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: ______________________ (City) ____ (State) Date ____ (MM) ____ (DD) ____ (YY)

____
Signature of Proposed Insured

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

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	Production Number	Date
Signature of Producer #2	Production Number	Date

Print or Stamp Producer #1 Name	Print or Stamp Producer #2 Name	Agency Name

Supplement to Application for Life Insurance

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

Proposed Insured Name (First, Middle Initial, Last)

Section A PERSONAL FINANCES

1 Complete Personal Finances for each person proposed for insurance.

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

2 Has any person proposed for insurance ever filed for bankruptcy? ☐ Yes ☐ No
If "Yes," please provide details: __________

3 What is the purpose of this insurance? (i.e., Keyman, Stock Redemption, Buy and Sell, Creditor, Estate Liquidity, Other): __________

4 How was the face amount determined? __________

Section B GENERAL INFORMATION

	Proposed Insured Yes	No
1 Has the person proposed for insurance: **(If answered "Yes," please list details in Section E)**		
(a) ever been declined, postponed, limited, denied reinstatement or asked to pay extra premium by any insurance company?	☐	☐
(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 within the last three years, or plan such activity in the next two years? **(If "Yes," complete the appropriate questionnaire.)**	☐	☐
(c) any intention of traveling or living outside the USA or Canada in the next two years? **(If "Yes," complete Foreign Travel Questionnaire.)**	☐	☐
(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? **(If "Yes," complete Aviation Questionnaire.)**	☐	☐
(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?	☐	☐
(f) been on probation within the last 12 months or are currently on probation?	☐	☐
(g) applied for, or currently receiving disability, hospital or medical benefits of any kind from any insurance company, government, employer or other source?	☐	☐
2 **In the past 10 years,** has the person proposed for insurance: **(If answered "Yes," please list details in Section D)**		
(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?	☐	☐
(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?	☐	☐
(c) been or are currently a member of Alcoholics Anonymous or Narcotics Anonymous?	☐	☐

Section C — UNDERWRITING INFORMATION

IF QUESTIONS 1 THROUGH 4 ARE ANSWERED "YES," PLEASE LIST ALL APPLICABLE CONDITIONS AND DETAILS IN SECTION E ON PAGE 3 OF THIS APPLICATION.

		Proposed Insured Yes	No
1	**In the past 10 years,** has the person proposed for insurance:		
	(a) had any illness, injury, surgery, hospitalization, medical examination or care not listed in Part I?	☐	☐
	(b) had or received treatment for any unexplained fever, weight loss, fatigue or chronic cough?	☐	☐
	(c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test?	☐	☐
	(d) been advised by a physician to have a surgical operation or procedure otherwise not listed?	☐	☐
2	Has the person proposed for insurance **ever** (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/ministroke?	☐	☐
	(b) any disease of the lungs or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema or shortness of breath?	☐	☐
	(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?	☐	☐
	(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?	☐	☐
	(e) any brain, nerve or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	☐	☐
	(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?	☐	☐
	(g) any disease or disorder of vision or hearing?	☐	☐
	(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid or other glandular/metabolic disorder?	☐	☐
3	If female, is the person proposed for insurance currently pregnant or has the person proposed for insurance ever had complications of pregnancy?	☐	☐
	(a) If currently pregnant, approximate delivery date ______________________________		
4	**In the past 12 months,** has the person proposed for insurance lost more than 10 pounds?	☐	☐
5	Does the person proposed for insurance currently have a personal physician?	☐	☐

(If "Yes," to question 5, please list details below.)

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

		Yes	No
6	**In the past 5 years,** has the person proposed for insurance consulted with a doctor or been hospitalized or treated for any other health condition?	☐	☐

(If "Yes," to question 6, 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

Section C — UNDERWRITING INFORMATION — continued

	Proposed Insured Yes	Proposed Insured No
7 **In the past 2 years,** has the person 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 7 (a), (b) or (c), please list details below. If more space is needed, use Section D.)

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

8 **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**
Father			
Mother			
Sibling 1			
Sibling 2			
Sibling 3			
Sibling 4			

Section D — ADDITIONAL DETAILS AND EXPLANATIONS — PROPOSED INSURED/OTHER PROPOSED INSURED

(Use Section E 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 E ADDITIONAL COMMENTS SUPPORTING APPLICATION

Section F PLEASE READ AND SIGN

Each of the undersigned, including the undersigned producer(s), certifies that he or she has read the completed Supplement to Application for Life Insurance and understands and agrees that:

All answers in this Supplement to Application for Life Insurance are true and complete and will be relied on by United of Omaha to determine insurability. I understand that this Supplement to Application for Life Insurance constitutes a part of the application for life insurance. I understand that any false statements or material misrepresentation may result in the loss of coverage under the policy.

Signed at: ______________________________ Date ____________
City State

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

Signature of Producer #1 Production Number Date

Signature of Producer #2 Production Number Date

Print or Stamp Producer #1 Name Print or Stamp Producer #2 Name Agency Name

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 Date
(if different from the Owner/Applicant)

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

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

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

United of Omaha Life Insurance Company

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, Braintree, 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.

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 COPY 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 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 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 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.

GIVE THIS COPY TO THE 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.

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:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 1-202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 1-800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 1-703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation , Office of Financial Management Washington, DC 20590 1-202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 1-202-720-7051

GIVE THIS COPY TO THE APPLICANT

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?	☐	☐
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?	☐	☐
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?	☐	☐
4	Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐

☐ **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 Agent/Broker 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)

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.

	Question	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?	☐	☐
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?	☐	☐
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?	☐	☐
4	Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐

☐ **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 Agent/Broker 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

Accelerated Death Benefit For Terminal and Chronic Illness Rider Disclosure

When the Accelerated Death Benefit paid under the terms of this rider, the life insurance policy to which this Rider is attached will terminate. Receipt of this Benefit may adversely affect you, your spouse's, or your family's eligibility for public assistance programs such as as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

This rider is part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the rider provisions. This rider is effective on the policy's date of issue.

Accelerated Benefit

While this rider is in force, you may choose to receive the Accelerated Death Benefit if the Insured is diagnosed as having a Terminal Illness or Chronic Illness.

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.

Chronically Ill means that a Physician has certified that the Insured is unable to perform (without substantial assistance from another person) at least two Activities of Daily Living and has been confined to a Nursing Home for 90 consecutive days or more.

The cumulative maximum accelerated death benefit amount available for Terminal Illness is $250,000 of the policy's current death benefit, minus the minimum Specified Amount as stated in the Change in Specified Amount provision of your policy. You may make a one-time election to receive the Accelerated Death Benefit if the Insured is diagnosed as having a Terminal Illness. The Accelerated Death Benefit amount for Terminal Illness will equal 94% of the amount you request, minus a $100 charge for acceleration for Terminal Illness.

The cumulative maximum accelerated death benefit amount available for Chronic Illness is the lesser of $250,000 of the policy's current death benefit or initial Specified Amount stated in the policy data pages, minus the minimum Specified Amount as stated in the Change in Specified Amount provision of your policy.

The Chronic Illness accelerated death benefit amount that you select will be reduced by an actuarially discounted amount determined by us, reflecting future guaranteed death benefits and planned premium using factors that include, but are not limited to, our assessment of the expected future mortality of the Insured and an interest rate that will not exceed the greater of :

(a) the current yield of the 90-day U.S. treasury bills as of the date of the accelerated death benefit amount request; or

(b) the current maximum statutory adjustable policy loan interest rate based on the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the accelerated death benefit amount.

There will be a charge for each acceleration for Chronic Illness. This charge will be deducted from the accelerated death benefit amount after the actuarial discount is applied.

There is no premium or cost of insurance charge for the Accelerated Death Benefit for Terminal and Chronic Illness Rider.

Effect of the Benefit Payment

You may choose to accelerate benefits for Chronic Illness multiple times, but may only do so once per calendar year. Only one Terminal Illness Accelerated Death Benefit Payment is payable under this rider. Multiple accelerations may not exceed a cumulative amount of $250,000.

The following adjustments are made due to an Accelerated Death Benefit Payment:

(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 accelerated death benefit paid;

(b) the current Specified Amount, current surrender value, and any outstanding loans and loan interest due will be reduced by the same percentage that the accelerated death benefit amount requested (before applying the actuarial discount when applicable) reduces the current death benefit; and

(c) any future monthly deductions and cost of insurance charges will be based on the reduced amount of insurance.

continued on next page

Accelerated Death Benefit For Terminal and Chronic Illness Rider Disclosure

When the Accelerated Death Benefit paid under the terms of this rider, the life insurance policy to which this Rider is attached will terminate. Receipt of this Benefit may adversely affect you, your spouse's, or your family's eligibility for public assistance programs such as as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

This rider is part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the rider provisions. This rider is effective on the policy's date of issue.

Accelerated Benefit

While this rider is in force, you may choose to receive the Accelerated Death Benefit if the Insured is diagnosed as having a Terminal Illness or Chronic Illness.

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.

Chronically Ill means that a Physician has certified that the Insured is unable to perform (without substantial assistance from another person) at least two Activities of Daily Living and has been confined to a Nursing Home for 90 consecutive days or more.

The cumulative maximum accelerated death benefit amount available for Terminal Illness is $250,000 of the policy's current death benefit, minus the minimum Specified Amount as stated in the Change in Specified Amount provision of your policy. You may make a one-time election to receive the Accelerated Death Benefit if the Insured is diagnosed as having a Terminal Illness. The Accelerated Death Benefit amount for Terminal Illness will equal 94% of the amount you request, minus a $100 charge for acceleration for Terminal Illness.

The cumulative maximum accelerated death benefit amount available for Chronic Illness is the lesser of $250,000 of the policy's current death benefit or initial Specified Amount stated in the policy data pages, minus the minimum Specified Amount as stated in the Change in Specified Amount provision of your policy.

The Chronic Illness accelerated death benefit amount that you select will be reduced by an actuarially discounted amount determined by us, reflecting future guaranteed death benefits and planned premium using factors that include, but are not limited to, our assessment of the expected future mortality of the Insured and an interest rate that will not exceed the greater of :

(a) the current yield of the 90-day U.S. treasury bills as of the date of the accelerated death benefit amount request; or

(b) the current maximum statutory adjustable policy loan interest rate based on the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the accelerated death benefit amount.

There will be a charge for each acceleration for Chronic Illness. This charge will be deducted from the accelerated death benefit amount after the actuarial discount is applied.

There is no premium or cost of insurance charge for the Accelerated Death Benefit for Terminal and Chronic Illness Rider.

Effect of the Benefit Payment

You may choose to accelerate benefits for Chronic Illness multiple times, but may only do so once per calendar year. Only one Terminal Illness Accelerated Death Benefit Payment is payable under this rider. Multiple accelerations may not exceed a cumulative amount of $250,000.

The following adjustments are made due to an Accelerated Death Benefit Payment:

(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 accelerated death benefit paid;

(b) the current Specified Amount, current surrender value, and any outstanding loans and loan interest due will be reduced by the same percentage that the accelerated death benefit amount requested (before applying the actuarial discount when applicable) reduces the current death benefit; and

(c) any future monthly deductions and cost of insurance charges will be based on the reduced amount of insurance.

continued on next page

Termination

This rider will terminate on the earliest of the following:

(a) the date the accelerated death benefit is paid for Terminal Illness; or
(b) when cumulative accelerations equal $250,000; or
(c) the date the policy terminates; or
(d) the maturity date of the policy.

I acknowledge receipt of this Disclosure Form.

Applicant's/Owner's Signature ______________________ Date ______________

Applicant's/Owner's Signature ______________________ Date ______________

I have provided this Disclosure Form to the Applicant.

Producer's Signature ______________________ Date ______________

Termination

This rider will terminate on the earliest of the following:

(a) the date the accelerated death benefit is paid for Terminal Illness; or
(b) when cumulative accelerations equal $250,000; or
(c) the date the policy terminates; or
(d) the maturity date of the policy.

I acknowledge receipt of this Disclosure Form.

Applicant's/Owner's Signature	Date
Applicant's/Owner's Signature	Date

I have provided this Disclosure Form to the Applicant.

Producer's Signature	Date

Notice and Consent for HIV-Related Testing

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

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.

GIVE THIS COPY TO THE APPLICANT

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

1st Copy — Proposed Insured **2nd Copy — Company**

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

1st Copy — Proposed Insured **2nd Copy — Company**

Acknowledgment Form

Name of Proposed Insured: **Age** **Sex**	**Name of Applicant (if other than Proposed Insured):**
Address of Proposed Insured: **City:** **State:** **ZIP:**	**Address of Applicant (if other than Proposed Insured):** **City:** **State:** **ZIP:**

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

Acknowledgment Form

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

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

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 ☐ Female ☐
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

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 ☐ Female ☐
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 Applicant/Owner