

Term Life Express Insurance 15, 20, 30

Term Life Complete Insurance 15, 20, 30

Application Submission Checklist - Texas



(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 in full.
 2. Sign and Date in all places indicated.
 3. See reverse side of this page for additional detailed information.
- Have Client Sign 'Authorization to Disclose Personal Information' (HIPAA Authorization)**
- Provide Client with MIB Group, Inc. Pre-Notice, Notice of Information Practices, Investigative Consumer Reports Notice, and Buyer's Guide**
- Have Client Sign 'Conditional Receipt' and provide copy to client**
- Monthly Bank Withdrawals**

If the Bank Service Plan (BSP) is selected, complete the authorization and check the appropriate box.
- Have Client Sign Notice and Consent for HIV-Related Testing where state required. (HIV Consent Form)**
- 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.
- Have Client Sign any state specific forms (if applicable) and provide copy to client**
- Attach copy of proposal illustration (if available)**
- 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 two parts to this application: 1) general application, and 2) necessary administrative forms that you will need at time of sale.

APPLICATION

Sections A and B: General Information

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

Sections C through F

- Complete Section C for all applicants
- Complete Section D only if applying for Term Life Complete
- Complete Section E only if applying for Term Life Complete
- Complete Section F only if applying for the Disability Income Rider and/or Disability Waiver of Premium Rider
- For all Sections, complete all information in full and provide details in the area provided.

Section G: Other Coverage and Replacement Information

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

Section H: Beneficiary Information

- Complete all Beneficiary information including relationship and Social Security Number.

Section I: Additional Comments

- Please provide additional information when necessary

Section J: Plan Information

- Select product type based on the following product criteria:

TERM LIFE EXPRESS	TERM LIFE COMPLETE
<input type="checkbox"/> Face amounts of \$50,000 - \$400,000	<input type="checkbox"/> Face amounts of \$100,000 - Plus
<input type="checkbox"/> Standard Non-Tobacco and Standard Tobacco Risk Classes	<input type="checkbox"/> Preferred Non-Tobacco, Preferred Tobacco, Standard Non-Tobacco, Standard Tobacco and Standard (Table Rated)
<input type="checkbox"/> Simplified Underwriting (Std. - through table 4)	<input type="checkbox"/> Full Underwriting

- Select any optional riders to be applied.

Section K: Dependent Children's Rider Information

- Complete all information if children are proposed for insurance.

Section L: Premium and Billing Information

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

Section M: 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.

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.

Conditional Receipt

- Sign and detach copy to leave with applicant.

Accelerated Death Benefit Rider Disclosure Form

- Sign and detach copy to leave with applicant.

Replacement Notice — complete if applicable

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

State Specific Forms — complete if applicable

- Be sure to include all state appropriate forms.

Section C

Health Information (Complete for all applicants)

If the person proposed for insurance answers “Yes” to questions 1 through 7 in this section, that person is not eligible for Term Life Express coverage. However, that person may still qualify for the fully underwritten Term Life Complete plan.

Proposed Insured		Other Proposed Insured	
Yes	No	Yes	No

1. Have any of the persons proposed for insurance ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are any of the persons proposed for insurance currently:				
(a) bedridden or confined to any hospital, nursing home, or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) using any of the following: walker, wheelchair, electric scooter, oxygen or catheter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have any of the persons 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:				
(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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Chronic Lung Disease (except mild Asthma), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Diabetes with onset before age 50 or with vascular or renal complications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell skin cancer)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Systemic Lupus or Scleroderma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 6 months , have any of the persons proposed for insurance:				
(a) required the assistance of another person, or a device of any kind for: bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) received, or been advised to have, any of the following: care in a nursing home, assisted living facility, or adult day care facility; or home health care services, or physical, occupational or speech therapy? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) applied for, received, or are you currently receiving disability benefits from any insurance company, government, employer or other source other than for maternity, fractures, spinal or back disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past 12 months , have any of the persons proposed for insurance:				
(a) been advised by a physician to have a surgical operation, diagnostic testing, treatment, or other procedure which has not been done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) consulted a physician for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. In the next 2 years , will either 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 10 years , have any of the persons proposed for insurance:				
(a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a physician or other health care provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had four or more moving violations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) been convicted of a felony?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) been hospitalized for high blood pressure or any mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section C

Health Information – continued

Proposed Insured		Other Proposed Insured	
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8. Have any of the persons proposed for insurance used (a) any form of tobacco or (b) any form of nicotine replacement therapy?
(If “Yes,” to question 8, please list details below.)

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Person Proposed for Insurance	Form of Tobacco/Nicotine Replacement Therapy	No. Per Day	Date Stopped

9. Name and address of personal physician (if over age 60 or applying for a fully underwritten product)

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Are the persons proposed for insurance citizens 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	<input type="checkbox"/> Permanent Resident Card (card No. _____) <input type="checkbox"/> Visa (specify type _____)	/ /
Other Proposed Insured	<input type="checkbox"/> Permanent Resident Card (card No. _____) <input type="checkbox"/> Visa (specify type _____)	/ /

Section D

Complete if applying for Term Life Complete

Proposed Insured		Other Proposed Insured	
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1. Have any of the persons proposed for insurance:
(If answered “Yes,” please list details below.)
- (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 the 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 the 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) within the last 10 years, been or are currently a member of Alcoholics Anonymous or Narcotics Anonymous?.....

Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide details to any “Yes” answer in question.

Section D

Complete if applying for Term Life Complete – continued

	Proposed Insured		Other Proposed Insured	
	Yes	No	Yes	No
2. In the past 10 years, have any of the persons proposed for insurance (If “Yes,” list details below):				
(a) had any illness, injury, surgery, hospitalization, medical examination or care not listed in Section C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) had or received treatment for any unexplained fever, weight loss, fatigue or chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) been advised by a physician to have a surgical operation or procedure otherwise not listed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) consulted with a health care provider or received care or treatment for depression, blackouts, tremors, or balance disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) had any disease or disorder of vision or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) had any cancer, tumor, blood/bleeding disorder, diabetes, thyroid or other glandular/metabolic disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 No. of Hospital, and/or Attending Physician

3. In the past 2 years, have any of the persons proposed for insurance, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication?	Yes	No	Yes	No
(If “Yes,” to question 3, please list details below.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

Section E

Personal Finances (Complete if applying for Term Life Complete)

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

(a) If applying for \$500,000 or more, complete Personal Finances for each person proposed for insurance.

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

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

Section F

Complete if Applying for the Disability Income Rider and/or Disability Waiver of Premium Rider

If the person proposed for insurance answers "Yes" to any of the questions 1 through 3 below, that person is not eligible for either Rider.

	Proposed Insured		Other Proposed Insured	
	Yes	No	Yes	No
1. In the past 10 years, have any of the persons 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?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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, or congenital disorders of the spinal column and back?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Any Mental or Nervous System Disorder (including Grand Mal Epilepsy)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the past 12 months, have any of the persons proposed for insurance regularly taken prescription medication(s) (e.g., Darvon/proproxyphene, narcotic or codeine derivative) for three consecutive months or more for the control of chronic pain?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently engaged in your occupation less than 30 hours per week?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. What is the monthly amount of any other disability insurance you have in force?.....	\$ _____		\$ _____	

Section G

Other Coverage and Replacement Information

- 1. Have you been offered a cash advance or any other consideration in order to induce you to purchase this policy?..... Yes No
- 2. Are you planning to enter into a finance arrangement where a lender or other third party will receive a portion of the death benefit beyond the repayment of principal and interest?..... Yes No

If "Yes" to questions 1 or 2, provide information in Section I.

- 3. List below all life insurance policies and/or annuity contracts on any of the Proposed Insureds that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) If none, check the following box. None
- 4. Have any of the Proposed Insureds had, or do they intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? Yes No

If "Yes" to question 4, complete the appropriate box(es) below.

The Producer shall comply with any additional state and/or Company replacement requirements.

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

Proposed Insured

Other Proposed Insured

Amount of Life Insurance Applied For:

\$

Amount of Life Insurance Applied For:

\$

Tobacco Status: Tobacco Non-Tobacco

Tobacco Status: Tobacco Non-Tobacco

Risk/Rate Class Applied For:

Risk/Rate Class Applied For:

Best Available (Risk Class Proposed _____)

Best Available (Risk Class Proposed _____)

APPLICATION FOR:

TERM LIFE EXPRESS

- 30 Year Level Term Life with 5 Year Guarantee
- 30 Year Level Term Life with 30 Year Guarantee
- 20 Year Level Term Life with 5 Year Guarantee
- 20 Year Level Term Life with 20 Year Guarantee
- 15 Year Level Term Life with 15 Year Guarantee

ADDITIONAL POLICY OPTIONS:

Return of Premium

TERM LIFE COMPLETE

- 30 Year Level Term Life with 5 Year Guarantee
- 30 Year Level Term Life with 30 Year Guarantee
- 20 Year Level Term Life with 5 Year Guarantee
- 20 Year Level Term Life with 20 Year Guarantee
- 15 Year Level Term Life with 15 Year Guarantee

ADDITIONAL POLICY OPTIONS:

Return of Premium

	Proposed Insured	Other Proposed Insured
30 Year Level Term Life with 5 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
30 Year Level Term Life with 30 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
20 Year Level Term Life with 5 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
20 Year Level Term Life with 20 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
15 Year Level Term Life with 15 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
<u>ADDITIONAL POLICY OPTIONS:</u>		
Return of Premium	<input type="checkbox"/>	<input type="checkbox"/>
TERM LIFE COMPLETE		
30 Year Level Term Life with 5 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
30 Year Level Term Life with 30 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
20 Year Level Term Life with 5 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
20 Year Level Term Life with 20 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
15 Year Level Term Life with 15 Year Guarantee	<input type="checkbox"/>	<input type="checkbox"/>
<u>ADDITIONAL POLICY OPTIONS:</u>		
Return of Premium	<input type="checkbox"/>	<input type="checkbox"/>

OPTIONAL RIDERS:

DISABILITY WAIVER OF PREMIUM RIDER

DEPENDENT CHILDREN'S RIDER*

Dependent Children's Rider Benefit Amount (Per dependent child)

ACCIDENTAL DEATH BENEFIT RIDER

Accidental Death Benefit Rider Amount

TOTAL DISABILITY INCOME RIDER

Total Disability Income Rider Benefit Period

Total Disability Income Rider Monthly Benefit.....

	Proposed Insured	Other Proposed Insured
DISABILITY WAIVER OF PREMIUM RIDER	<input type="checkbox"/>	<input type="checkbox"/>
DEPENDENT CHILDREN'S RIDER*	<input type="checkbox"/>	Not Available
Dependent Children's Rider Benefit Amount (Per dependent child)	<input type="checkbox"/> \$5,000 (select one) <input type="checkbox"/> \$10,000	
ACCIDENTAL DEATH BENEFIT RIDER	<input type="checkbox"/>	<input type="checkbox"/>
Accidental Death Benefit Rider Amount	\$ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	\$ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
TOTAL DISABILITY INCOME RIDER	<input type="checkbox"/>	<input type="checkbox"/>
Total Disability Income Rider Benefit Period	<input type="checkbox"/> 18 months (select one) <input type="checkbox"/> 30 months	<input type="checkbox"/> 18 months (select one) <input type="checkbox"/> 30 months
Total Disability Income Rider Monthly Benefit.....	\$ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	\$ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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

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

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

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

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

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

AGREEMENT:

Each of the undersigned, including the Producer(s), certify that we have read the completed application.

I, the undersigned, understand and agree that:

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

– continued on next page –

Section M

Please Read, Sign and Submit with Application – continued

- 9. I have received the MIB Group, Inc. Pre-Notice, the Notice of Information Practices, and a Life Insurance Buyer’s Guide before completing this application.
- 10. If the Applicant is other than the person proposed for insurance, the Applicant will own the policy.
- 11. No Producer can: **(a)** waive or change any Receipt or policy provision; or **(b)** agree to issue a policy.
- 12. **Fraud Warning:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGNATURE(S):

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

Signed at: _____ State Date MM DD YY

City

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 Other Proposed Insured (if applicable)

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

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

PRODUCER STATEMENT:

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

Signature of Producer #1

Signature of Producer #2

Producer No. _____ Date _____

Producer No. _____ Date _____

Print or Stamp Producer #1 Name

Print or Stamp Producer #2 Name

Agency Name

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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

Meanings of Terms

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

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

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

“Specified Companies” means:

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

Authorization to Disclose

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

Purposes

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

Potential For Redisclosure

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

Failure to Sign

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

Expiration and Revocation

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

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

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

Copy

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

Names and Signatures

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

_____ Printed Name of Proposed Insured	_____ Spouse’s Printed Name (If Proposed Insured)	_____ If children are to be insured, their printed names
_____ Signature of Proposed Insured	_____ Signature of Spouse (If Proposed Insured)	_____ Signature of Parent or Guardian (If Proposed Insured is a Minor)
_____ Date	_____ Date	_____ Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Accelerated Death Benefit Rider Disclosure Form

United of Omaha Life Insurance Company
Omaha, Nebraska

When the Accelerated Death Benefit is paid under the terms of this Rider, the life insurance policy to which this Rider is attached will terminate. Receipt of this benefit may affect your, your spouse's, or your family's eligibility for public assistance programs such 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.

The Accelerated Death Benefit may or may not be taxable. The Accelerated Death Benefit offered under this Rider is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Death Benefit qualifies for such favorable tax treatment, the benefit will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive the Accelerated Death Benefit excludable from income under federal law.

This Rider is part of the policy to which it is attached. It is subject to all the policy provisions that are not inconsistent with the Rider provisions. If the provisions of the Rider and those of the policy do not agree, the provisions of the Rider apply. The Rider is effective on the policy's issue date.

Accelerated Death Benefit

While this Rider is in force, you may make a one-time election to receive the accelerated death benefit if the Insured is diagnosed as having a terminal illness. Terminal illness means a medical condition that, with a reasonable degree of certainty, will result in the Insured's death within 24 months or less from the date a physician signs the statement of proof of terminal illness.

The accelerated death benefit amount will equal 92% of the death benefits payable under the policy.

There is no premium charge for this benefit.

Termination

The policy and all Riders attached to it will terminate when the accelerated death benefit is paid. Any Rider that covers the life of another person, and that includes a conversion provision, may be converted to a new policy as specified in the Rider.

This Rider will terminate on the earliest of the following:

- (a) the date the accelerated death benefit is paid;
- (b) the date the policy terminates; or
- (c) the Expiration Date of the policy.

I acknowledge receipt of this Disclosure Form.

Applicant Signature

Date

Applicant Signature

Date

Producer Statement (if applicable):

I have provided this Disclosure Form to the Applicant.

Producer Signature

Date

Accelerated Death Benefit Rider Disclosure Form

United of Omaha Life Insurance Company
Omaha, Nebraska

When the Accelerated Death Benefit is paid under the terms of this Rider, the life insurance policy to which this Rider is attached will terminate. Receipt of this benefit may affect your, your spouse's, or your family's eligibility for public assistance programs such 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.

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- (c) the Expiration Date of the policy.

I acknowledge receipt of this Disclosure Form.

Applicant Signature

Date

Applicant Signature

Date

Producer Statement (if applicable):

I have provided this Disclosure Form to the Applicant.

Producer Signature

Date

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 Massachusetts.

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.

United of Omaha Life Insurance Company - 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.

Remove and Give to Proposed Insured

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 Massachusetts.

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.

United of Omaha Life Insurance Company - 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.

Remove and Give to Other Proposed Insured

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Conditional Receipt

If no money was collected with the application, then a Conditional Receipt should not be provided to the applicant. This includes the situation when the initial premium will be paid by Electronic Funds Transfer.

Initial Premium of \$ _____ was received from _____
for a life insurance application on _____, dated _____
(person(s) proposed for insurance)

(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO UNITED OF OMAHA LIFE INSURANCE COMPANY ("UNITED OF OMAHA"). DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if **all** of the following conditions have been completely met:

- (i) payment of the full first premium according to the method of payment selected in the application;
- (ii) each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United of Omaha then in force, without modification of the plan, premium rate, benefits, class and amount of coverage applied for; and
- (iii) all of the statements and answers in the application are true and complete when made, and there is no material misrepresentation in the application furnished to United of Omaha.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado, Missouri, and North Dakota, within one year), or (c) the application is not accepted by United of Omaha, no insurance coverage will be provided under this Conditional Receipt, and United of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

For each person proposed for insurance, the maximum death benefit payable under this Conditional Receipt will be the lesser of: (a) the total death benefit payable under all Receipts and all pending applications with United of Omaha relating to the person proposed for insurance, or (b) \$100,000. This Receipt provides no coverage for policy Riders.

If each person proposed for insurance choose(s) to pay the full initial premium by electronic funds transfer, he/she/they understand and agree that the full initial premium will not be considered to be paid by United of Omaha until it is received by United of Omaha.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date United of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either United of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

In no event will benefits be paid for the same loss under both this Conditional Receipt and any life insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: _____

Signed at: _____
City State

Signature of Proposed Insured

Signature of Other Proposed Insured (if applying for insurance)

Signature of Producer

Signature of Producer

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Conditional Receipt

If no money was collected with the application, then a Conditional Receipt should not be provided to the applicant. This includes the situation when the initial premium will be paid by Electronic Funds Transfer.

Initial Premium of \$ _____ was received from _____
for a life insurance application on _____, dated _____
(person(s) proposed for insurance)

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- (i) payment of the full first premium according to the method of payment selected in the application;
- (ii) each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United of Omaha then in force, without modification of the plan, premium rate, benefits, class and amount of coverage applied for; and
- (iii) all of the statements and answers in the application are true and complete when made, and there is no material misrepresentation in the application furnished to United of Omaha.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado, Missouri, and North Dakota, within one year), or (c) the application is not accepted by United of Omaha, no insurance coverage will be provided under this Conditional Receipt, and United of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

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Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date United of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either United of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

In no event will benefits be paid for the same loss under both this Conditional Receipt and any life insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: _____

Signed at: _____
City State

Signature of Proposed Insured

Signature of Other Proposed Insured (if applying for insurance)

Signature of Producer

Signature of Producer

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.

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

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

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Signature of Proposed Insured or Parent/Guardian

Date Signed

Name of Proposed Insured

Address



Summary of Premium Provisions
Statement of Understanding

The policy you have applied for is indeterminate premium insurance.

I understand that the premiums for the policy for which I am applying are guaranteed for only:

TERM LIFE EXPRESS OR TERM LIFE COMPLETE
<input type="checkbox"/> 20/5 guarantee period = 5 years
<input type="checkbox"/> 20/5 Return of Premium, guaranteed period = 5 years
<input type="checkbox"/> 30/5 guaranteed period = 5 years
<input type="checkbox"/> 30/5 Return of Premium, guaranteed period = 5 years

TERM LIFE 10	TERM LIFE 15	TERM LIFE 20
<input type="checkbox"/> 10 years	<input type="checkbox"/> 15 years	<input type="checkbox"/> 20 years

I further understand that the current schedule of premiums may change after the guaranteed period checked above. After that period, premiums may stay the same, go down, or go up, but will never be higher than the guaranteed maximum premiums. Any changes in premiums will be made on a policy anniversary.

Name of Applicant: _____

Date: _____

Signature of Applicant: _____



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Statement of Understanding

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<input type="checkbox"/> 20/5 guarantee period = 5 years
<input type="checkbox"/> 20/5 Return of Premium, guaranteed period = 5 years
<input type="checkbox"/> 30/5 guaranteed period = 5 years
<input type="checkbox"/> 30/5 Return of Premium, guaranteed period = 5 years

TERM LIFE 10	TERM LIFE 15	TERM LIFE 20
<input type="checkbox"/> 10 years	<input type="checkbox"/> 15 years	<input type="checkbox"/> 20 years

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Name of Applicant: _____

Date: _____

Signature of Applicant: _____