Fixed Life Insurance Application – National 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.
2. Be sure to leave all applicable forms with the Proposed Insured.
3. Sign and date in all places indicated.
4. See reverse side of this page for additional detailed information.

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

☐ **Privacy Authorizations —** Both the HIPAA and MIB authorizations are to be signed and returned with the application

☐ **Accelerated Benefit Rider ($50,000-$500,000 face amount.)**

☐ **Attach copy of the Cover Letter (if appropriate)**

☐ **For Mutual of Omaha career agents only, attach copy of Financial Profiles printout.**

☐ **Attach copy of the Illustration and, if applicable, Replacement Forms and/or HIV Consent Form**

☐ **Complete the Oral Fluid Test or schedule Paramed examination, as applicable**

APPS 1-800-635-1677 PORTAMEDIC 1-800-765-1010

☐ **Indicate underwriting requirements initiated or completed on the Proposed Insured(s)**

Primary Proposed Insured

☐ Client Profile Interview
☐ Oral Fluid Test
☐ Blood Profile
☐ Urinalysis
☐ Physical Data
☐ Long Form Exam
☐ EKG
☐ Treadmill EKG
☐ Chest X-ray
☐ Inspection Report
☐ MD Exam

Spouse

☐ Client Profile Interview
☐ Oral Fluid Test
☐ Blood Profile
☐ Urinalysis
☐ Physical Data
☐ Long Form Exam
☐ EKG
☐ Treadmill EKG
☐ Chest X-ray
☐ Inspection Report
☐ MD Exam

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

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☐ **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.

Please Follow Instructions Shown Below Carefully

To The Producer:

- Complete the Application, and if applicable, the Temporary Life Insurance Agreement and Receipt.
- Tear off and discuss the MIB Group, Inc. Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Summary of Rights Under the Fair Credit Reporting Act and Investigative Consumer Reports pages and give them to the Proposed Insured
- Have both the HIPAA Authorization to Disclose Personal Information to United of Omaha Life Insurance Company and Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB") signed and dated and return both Authorizations to the Home Office.
- Assure that all applicable questions are answered in clear, printed fashion.
- Be sure the application is signed by the Proposed Insured(s) and the Applicant if other than the Proposed Primary Insured.
- Any changes should be initialed by the Proposed Insured(s) and, if applicable, the Applicant.
- Use age last birthday.
- Always provide the attached Temporary Life Insurance Agreement and Receipt when you accept a premium. See the Life Insurance Temporary Insurance Agreements Guidelines below.

Life Insurance Temporary Insurance Agreement (TIA) Guidelines (the "Guidelines"):

Important:

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

Do Not Collect Premium If:

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

If no premium is collected then:

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

Collect Premium If The Following Requirements Are Met:

1. The total amount of insurance applied for does not exceed $500,000
2. All four questions on the TIA are answered "No"

If the above two requirements for a TIA are met and premium is collected:

1. Complete the TIA form
2. Insert the date
3. Obtain the client(s) signature(s)
4. Leave one copy of the completed TIA form with the client
5. Submit the second copy of the TIA to the Home Office with the Application

Life Insurance Application

Administration Use Only

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

☐ ADULT LIFE
☐ JUVENILE LIFE

☐ New Business
☐ Replacement/ Conversion

☐ Addition to Existing Policy Number___________

Section A — Proposed Primary Insured

1 Proposed Primary Insured: ________________ Social Security Number:_____-_____-_______
2 Legal Residence Address: ________________
3 Mailing Address for Premium Notices: ________________
4 E-mail Address: ________________
5 Home Phone Number: (_____)________________ Best Time to Call:________________
Cell Phone Number: (_____) ________________ Business Phone Number: (_____)________
6 Are you and all persons proposed for insurance a citizen(s) of the United States? ☐ Yes ☐ No If "No," include a photocopy of the permanent residency Visa for each Proposed Insured.
7 Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age:________ Birthplace (state): ____________
8 Height: ________ Weight:________
9 Driver's License Number: ________________ State of Issue: ________________
10 Occupation: ________________ Duties: ________________
11 Name of Firm or Employer: ________________ Business Phone Number: (____)________
12 Current Annual Income: $ ________________
13 Owner's Name (If different from Proposed Primary Insured or if Proposed Primary Insured is under Age 15): ___________

____

14 Owner's Address:________________________________
Street No., Apt. No. City, State ZIP
15 Owner's Relationship to Proposed Primary Insured: ________________ Social Security No. (or Taxpayer ID No.): ___________
16 Owner's Primary Phone Number: (____)________________

Section B — Spouse/Child(ren)

Complete Only If Spouse/Child(ren) Are Proposed For Insurance. (Child must be 18 years or younger at time of application.)

First Name, Middle Initial, Last Name	Social Security Number	Relationship to Proposed Primary Insured	Birth Date Mo/Day/Yr	Age	Sex	Ht.	Wt.

Spouse's Birthplace (state): ____________________
Spouse's Occupation: ________________ Spouse's Current Annual Income: $ ________________
Spouse's Driver's License Number: ________________ State of Issue: ________________
Spouse's E-mail Address: ________________
Do all family members proposed for insurance live with the Proposed Primary Insured? ☐ Yes ☐ No If "No," explain and give name, address and phone number where family member can be contacted. ________________

____

Section C — Plan Information

Plan of Insurance: ______________________ Face Amount: $ ____________

Death Benefit Options: (Universal Life Only)
☐ Option 1: Accumulation Value Included in Specified Amount
☐ Option 2: Accumulation Value In Addition to Specified Amount

Riders: **Amounts**

☐ Waiver of Premium or Disability

☐ Accidental Death Benefit ____________

☐ Additional Insured Rider (Primary Insured) ____________

The beneficiary of the Accidental Death Benefit Rider and the Additional Insured Rider on the Primary Insured will be the Beneficiary named in this application or named in a later endorsement to the policy.

☐ Children's Rider ____________ (Units)

☐ Spouse Rider ____________

☐ Additional Insured Rider (Spouse) ____________

☐ Other (Please Specify) ____________

The beneficiary for (1) an Additional Insured Rider on the Spouse, or (2) an Additional Insured Rider on a person other than the Primary Insured, will be the Primary Insured unless you designate otherwise in Section I of this application.

Premium:

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

Planned Modal Premium: $ ____________

Method of Payment: ☐ Bank Service Plan ☐ Quarterly ☐ Semiannual ☐ Annual ☐ PRD

Complete only for PRD or Association or Franchise Coverage:

Full Name of Group/Organization: ____________ Date Joined: ____________

Beneficiary Information:

Primary Beneficiary: ____________ Relationship: ____________

Address: ____________

SSN/TIN: ____________ DOB: ____________

Contingent Beneficiary: ____________ Relationship: ____________

Address: ____________

SSN/TIN: ____________ DOB: ____________

Unless otherwise specified, payments will be shared equally by all Primary Beneficiaries who survive the Proposed Primary Insured; if none, by all Contingent Beneficiaries who survive. The right to change the beneficiary is reserved unless otherwise stated.

If more space is needed to provide Beneficiary Information, please use Section I.

Section D — Other Coverage and Replacement Information

1 List below all life insurance policies and/or annuity contracts on any Proposed Insured(s) that are now in force, now pending, or that have terminated in the last 13 months. (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 you had, or do you intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, subjected to borrowing, or otherwise discontinued because of this application? ☐ **Yes** ☐ **No** If "Yes," check 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?
				☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
				☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
				☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
				☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Section E — Underwriting Information — Proposed Primary Insured

Please Print. All Questions Relate to the Proposed Primary Insured.

1 Name, address and telephone number of personal physician of the Proposed Primary Insured: ______________________

____

(a) Date last seen: ____________ (b) State reason, findings and treatment: ______________________

____

____

2 Name, address and telephone number of any other physician consulted in the last 5 years by the Proposed Primary Insured: ______________________

(a) Date: __________ (b) State reason, findings and treatment: ______________________

____

____

IF QUESTIONS 3 THROUGH 7 ARE ANSWERED "YES," PLEASE LIST ALL APPLICABLE CONDITIONS AND LIST DETAILS IN SECTION F.

3 Have you **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: **Yes No**

(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? .... ☐ ☐

4 Have you **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? .... ☐ ☐

5 During the **last 10 years**, have you:

(a) had any illness, injury, surgery, hospitalization, medical examination or care not listed above? .... ☐ ☐

(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? .... ☐ ☐

6 Are you pregnant? .... ☐ ☐

Enter approximate delivery date: ____________________

Any complications with this pregnancy or previous pregnancies? .... ☐ ☐

7 During the **last 12 months**, have you lost more than 10 pounds? .... ☐ ☐

8 During the **last 2 years**, have you, (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 8 (a), (b) or (c), please list details below.) If more space is needed, use Section I.

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

Section E — Underwriting Information — Proposed Primary Insured (continued)

9 During the **last 10 years,** have you: **(If answered "Yes" please list details in Section F)**

		Yes	No
(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 you currently a member of Alcoholics Anonymous or Narcotics Anonymous?	☐	☐

10 During the **last 10 years**, have you used:

		Yes	No
(a)	any form of tobacco?	☐	☐
(b)	any form of nicotine replacement therapy (for example — nicotine gum, patch, or spray?)	☐	☐

If you answered "Yes" in 10 (a) or (b), please provide details below.

Form of Tobacco/Nicotine Replacement Therapy	Number Per Day	Date Stopped

11 Have you: (If answered "Yes" please list details in Section I).

		Yes	No
(a)	ever been declined, postponed, limited, denied reinstatement or asked to pay an 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 six months?	☐	☐
(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 convicted of a felony within the last 10 years?	☐	☐
(g)	been on probation within the last 12 months or are you currently on probation?	☐	☐
(h)	applied for, or are you currently receiving disability, hospital or medical benefits of any kind from any insurance company, government, employer or other source?	☐	☐

12 Please complete:

Family History	Age if Living	If Living, Present Health	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Siblings				

Section F — Additional Details and Explanations — Proposed Primary Insured

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

Ques. No.	Condition, Injury, Symptom of Ill Health or Findings of Examination (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 G — Underwriting Information — Spouse/Child(ren)

Please Print. All Questions Relate to Spouse and/or Child(ren) who is/are proposed for insurance.

1 Name, address and telephone number of personal physician of the Spouse/Child(ren): ____________________

____

(a) Date last seen: __________ (b) State reason, findings and treatment: ____________________

____

____

2 Name, address and telephone number of any other physician consulted in the last 5 years by the Spouse/Child(ren):

____

(a) Date:__________ (b) State reason, findings and treatment: ____________________

____

____

IF QUESTIONS 3 THROUGH 7 ARE ANSWERED "YES," PLEASE LIST ALL APPLICABLE CONDITIONS AND LIST DETAILS IN SECTION H.

Question	Spouse Yes	Spouse No	Child(ren) Yes	Child(ren) No
3 Has the Spouse/Child(ren) **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?	☐	☐	☐	☐
4 Has the Spouse/Child(ren) **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?	☐	☐	☐	☐
5 During the **last 10 years**, has the Spouse/Child(ren):				
(a) had any illness, injury, surgery, hospitalization, medical examination or care not listed above?	☐	☐	☐	☐
(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?	☐	☐	☐	☐
6 Is spouse/child(ren) pregnant?	☐	☐	☐	☐
Enter approximate delivery date: __________				
Any complications with this pregnancy or previous pregnancies?	☐	☐	☐	☐
7 During the **last 12 months** has the Spouse/Child(ren) lost more than 10 pounds?	☐	☐	☐	☐
8 During the **last 2 years**, has the Spouse/Child(ren), (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 8 (a), (b) or (c), please list details below.) If more space is needed, use Section I.

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

Section G — Underwriting Information — Spouse/Child(ren) (continued)

		Spouse Yes	Spouse No	Child(ren) Yes	Child(ren) No
9	During the **last 10 years**, has the Spouse/Child(ren): **(If you answered "Yes" please list details in Section H)**				
(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 you currently a member of Alcoholics Anonymous or Narcotics Anonymous?	☐	☐	☐	☐
10	During the **last 10 years** has the Spouse/Child(ren) proposed for insurance used:				
(a)	any form of tobacco?	☐	☐	☐	☐
(b)	any form of nicotine replacement therapy (for example — nicotine gum, patch, or spray?)	☐	☐	☐	☐

If you answered "Yes" in 10 (a) or (b), please provide details below.

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

		Spouse Yes	Spouse No	Child(ren) Yes	Child(ren) No
11	**Has the Spouse/Child(ren) proposed for insurance: (If answered "Yes," please list details in Section I)**				
(a)	ever been declined, postponed, limited, denied reinstatement or asked to pay an 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, hang gliding, skydiving, skin diving or scuba diving within the last three years, or plan such activity in the next six months?	☐	☐	☐	☐
(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 convicted of a felony within the last 10 years?	☐	☐	☐	☐
(g)	been on probation within the last 12 months or are you currently on probation?	☐	☐	☐	☐
(h)	applied for, or are you currently receiving disability, hospital or medical benefits of any kind from any insurance company, government, employer or other source?	☐	☐	☐	☐

12 Complete for Spouse:

Family History	Age if Living	If Living, Present Health	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Siblings				

Section H — Additional Details and Explanations — Spouse/Child(ren)

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

Ques. No.	Name	Condition, Injury, Symptom of Ill Health or Findings of Examination (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

Additional Comments Supporting Application

Section J — Agreement Section

Each of the undersigned, including the undersigned Producer(s), certify that they have read the completed application and agree to the following:

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 In order for United of Omaha to issue a policy as a result of this application: **(a)** all Proposed Insureds must complete all required examinations and tests (medical, paramedical, laboratory), **(b)** 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, **(c)** the application must be approved for issue by United of Omaha's Underwriting Department. If **(a)**, **(b)** or **(c)** 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 In order for the policy to go into effect, (a) all policy delivery requirements must be completed and accepted by the Proposed Insured and Policyowner, and (b) there must be no change in either the health or habits of any Proposed Insured that would change the answers to any questions on the application prior to: (i) the date the application is approved for policy issued, or, if later (ii) the date the full initial premium is paid. The Proposed Insured or Applicant/Owner/Trustee shall immediately notify United of Omaha's Underwriting Department of any change in health or habits of any Proposed Insured that will change any statement or any answer to any question in the application.

4 If, prior to policy delivery, any Proposed Insured dies, or there has been a change in the health or habits of any Proposed Insured, the Producer cannot deliver the policy and must return it to the Home Office.

5 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.

6 I have received the MIB Group, Inc. Pre-Notice, a Fair Credit Reporting Act Disclosure Statement, a Notice of Information Practices, an Investigative Consumer Reports Notice, a Summary of Rights Under the Fair Credit Reporting Act, and a Life Insurance Buyer's Guide before completing this application.

7 If the Applicant is other than the Proposed Primary Insured, the Applicant will own the policy.

8 No producer can waive or change any Receipt or policy provision or agree to issue a policy.

9 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.

I have read and understand this Agreement Section and any Receipt provided, and I approve all my answers as recorded in this application.

Signed at: ______________________________ ______________________ Date ____________________
City State

____
Signature of Proposed Primary Insured (Age 15 and Over)

____
Signature of Spouse (if a Proposed Insured)

____
Signature of Parent or Guardian (if Proposed Insured under age 15)

____
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))

10 In addition to the above Agreement, has the Proposed Insured informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? ☐ Yes ☐ No

11 Do you, the Producer(s), know or have reason to believe that the policy applied for has replaced or will replace any existing life insurance policy(ies) and/or annuity contract(s)? ☐ 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.

12 Did you, the Producer(s), give the Proposed Primary Insured the MIB Group, Inc. Pre-Notice, the Fair Credit Reporting Act Disclosure Statement, the Notice of Information Practices, the Investigative Consumer Reports Notice, the Summary of Rights Under the Fair Credit Reporting Act and the Life Insurance Buyer's Guide? ☐ Yes ☐ No (If "No," explain.)

____

13 In the presence of the Proposed Primary Insured/Spouse have you asked each question exactly as written and recorded the answers completely and accurately? ☐ Yes ☐ No (If "No," explain.) ______________________

______________________________ ____________ ______________________________
Signature of Producer Date Print or Stamp Producer Name

______________________________ ____________ ______________________________
Signature of Producer Date Print or Stamp Producer Name

Appendix 1 - 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

Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB")

Meanings of Terms

"MIB Group, Inc. (MIB)" means: a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

"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.

"Specified Companies" means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, 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 Receive and Disclose

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children 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 may submit a claim for benefits.

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.

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
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

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

____

____

______________________ Signature of Proposed Insured | ______________________ Date

______________________ Signature of Spouse (If Proposed Insured) | ______________________ Date

______________________ Signature of Parent or Guardian (If Proposed Insured is a Minor) | ______________________ Date

Producer's Report

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

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

Full Name ______________________ Address ______________________ Birth Date __________

Amount of life insurance carried with all companies $ ____________ If none, state why______________________

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

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

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

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

4 When did you last see the Proposed Primary Insured? ______________________

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

____

____

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

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

8 Is a paramed exam to be completed? ☐ Yes ☐ No (b) Name of examiner or paramedical facility__________________

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

Address	From	To

Details

____

____

____

Division Office/Brokerage General Agency/Bank Information

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

Reviewed By: ____
(Division Office, **BGA, Bank Name**)

____
(DSM, **Assistant Wholesaler or Authorized Reviewer's** Printed Name)

Agency Stamp	DSM Stamp

Bank Service Plan Request Form

I List the policies/certificates to be paid by your checking account.

(1) ______________________ Plan of Insurance ______________________ Proposed Insured

(2) ______________________ Plan of Insurance ______________________ Proposed Insured

(3) ______________________ Plan of Insurance ______________________ Proposed Insured

II Complete the following only if you are adding the above coverages to an existing BSP account.

______________________ Insured Under Existing BSP ______________________ Existing BSP Policy Number

III Specify the date premiums will be withdrawn (1st through the 28th of the month): ______________________

IV ______________________ Routing Number and Transit Number ______________________ Account Number

Or, attach your voided check from the account where premiums will be withdrawn.

Bank Service Plan Authorization

As a convenience to me, I authorize Mutual of Omaha Insurance Company and/or its affiliated companies* to withdraw funds from my account.

I also authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to the appropriate company(ies) below. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Date ______________________

______________________ Authorized Signature as Shown on Account

______________________ Joint Account or Other Authorized Signature

*Mutual *of* Omaha Insurance Company
*United *of* Omaha Life Insurance Company
*United World Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

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: Post Office Box 105, Essex Station, Boston, MA 02112.

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.

Fair Credit Reporting Act Disclosure Statement

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

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

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

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

United of Omaha Life Insurance – Notice of Information Practices

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

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

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

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

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

Investigative Consumer Reports Notice

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

GIVE THIS NOTICE TO THE APPLICANT

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit 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 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

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.

		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 __________ (Proposed Insured(s)) and this Temporary Insurance Agreement is not in effect.**

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)

Accelerated Benefit Rider Disclosure

United of Omaha Life Insurance Company

When the Accelerated Benefit is paid under the terms of this rider, the life insurance policy to which this rider is attached will terminate. The Accelerated Benefit may be taxable. Receipt of this Benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting this Benefit.

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 make a one-time election to receive the Accelerated 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 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

The Accelerated Benefit amount will equal:
- (a) 94% of the net death benefit of the policy; plus
- (b) 94% of any term insurance rider on the Insured's life that is attached to the policy.

The Accelerated Benefit is not available if the sum of the death benefit under the policy and the death benefit under any term insurance rider on the Insured's life is greater than $500,000.

There is no premium or cost of insurance charge for this benefit.

Term life insurance riders, if attached to the base plan, will be terminated, but are included in the Accelerated Benefit calculation. Non-term life insurance riders such as the Accidental Death Benefit will terminate when the Accelerated Benefit option is invoked.

Any outstanding loans will be deducted from the death benefit before the Accelerated Benefit is calculated.

Termination

The policy and all riders attached to it will terminate when the Accelerated 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 Benefit is paid;
- (b) the date the policy terminates; or
- (c) the maturity date of the policy.

I acknowledge receipt of this Disclosure Form.

______________________________ ______________________________

Applicant Signature Date

I have provided this Disclosure Form to the Applicant.

______________________________ ______________________________

Producer Signature Date

Accelerated Benefit Rider Disclosure

United of Omaha Life Insurance Company

When the Accelerated Benefit is paid under the terms of this rider, the life insurance policy to which this rider is attached will terminate. The Accelerated Benefit may be taxable. Receipt of this Benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting this Benefit.

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 make a one-time election to receive the Accelerated 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 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

The Accelerated Benefit amount will equal:
- (a) 94% of the net death benefit of the policy; plus
- (b) 94% of any term insurance rider on the Insured's life that is attached to the policy.

The Accelerated Benefit is not available if the sum of the death benefit under the policy and the death benefit under any term insurance rider on the Insured's life is greater than $500,000.

There is no premium or cost of insurance charge for this benefit.

Term life insurance riders, if attached to the base plan, will be terminated, but are included in the Accelerated Benefit calculation. Non-term life insurance riders such as the Accidental Death Benefit will terminate when the Accelerated Benefit option is invoked.

Any outstanding loans will be deducted from the death benefit before the Accelerated Benefit is calculated.

Termination

The policy and all riders attached to it will terminate when the Accelerated 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 Benefit is paid;
- (b) the date the policy terminates; or
- (c) the maturity date of the policy.

I acknowledge receipt of this Disclosure Form.

______________________________	______________________________
Applicant Signature	Date

I have provided this Disclosure Form to the Applicant.

______________________________	______________________________
Producer Signature	Date

Life Insurance Buyer's Guide

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

This Guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Reprinted by: United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175

Important Things to Consider

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance also can be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.

- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also, ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period — even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value In Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up the policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies — those that offer basically the same benefits, with premiums payable for the same length of time.

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies, in this case, amounts paid are likely to change more rapidly when interest rates change.

National Association of Insurance Commissioners
120 West 12th Street
Suite 1100
Kansas City, MO 64105-1925
(816) 842-3600

Important Notice Regarding The Replacement Of Your Policy Of Life Insurance

United of Omaha Life Insurance Company
☐ ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476

You have been offered a policy to replace all or part of your existing policy of life insurance.

Before you replace your existing policy, you should consider whether you could suffer a **financial loss** under the new policy because of your **age** or the condition of your **health**. You should also consider whether you will pay more for premiums because of your age or health.

You **will** incur additional costs to acquire the new policy, including the payment of commissions to the agent advocating the replacement of your existing policy.

To make an informed decision about the replacement of your policy, you should discuss the provisions of your existing policy with your agent or the company which issued it to determine whether your policy can be changed to meet your present needs.

Your new policy provides 10 days for you to decide whether you wish to keep it.

The agent who is offering to replace your existing policy is required to obtain your signature on this notice. Also, he or she will be notifying your existing insurance company that you are considering the replacement of your policy.

I have read this notice and received a copy of it for my records.

Applicant's Signature	Date	Agent's Signature	Date

Important Notice Regarding The Replacement Of Your Policy Of Life Insurance

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I have read this notice and received a copy of it for my records.

______________________	__________	______________________	__________
Applicant's Signature	Date	Agent's Signature	Date

Replacement Analysis Form

United of Omaha Life Insurance Company

Mutual of Omaha

Replacement Determination

Replacement of life insurance or an annuity policy is taking place if, following purchase of this new coverage, any existing coverage will be:

(1) lapsed, surrendered, partially surrendered, withdrawn upon, terminated, or assigned to the insurer
(2) changed or modified into paid-up insurance or continued as extended term insurance
(3) reduced with respect to benefits, premiums, or the period of time it will be in force
(4) reissued with a reduction in face amount
(5) borrowed against
(6) used to finance the proposed policy (by surrender, withdrawal or loan against any existing policy to pay premiums on the new policy)

United of Omaha requires information be provided to the Applicant to compare a new life insurance policy or annuity contract with existing coverage, to determine if a replacement is desired. (There may be additional forms required by the state). **The Applicant should discuss the information in detail with the agent, and carefully weigh the advantages and disadvantages of both policies.**

NOTICE TO APPLICANT: Replacing an existing life insurance policy with a new one may not be in your best interest. It is important that you compare the advantages and disadvantages of this replacement, and ask questions when you do not understand.

Replacement Analysis

	Insurer Name	Policy or Contract Number	Type of Policy: Term (T) or Permanent (P)	Check box if used to finance proposed policy
1.	______	______	______	☐
2.	______	______	______	☐
3.	______	______	______	☐

The following provisions have been discussed (check all that apply):

☐ annual premium
☐ suicide exclusion provision
☐ guaranteed death benefit
☐ surrender charge period and amount
☐ loan provision and loan interest rate
☐ face amount
☐ contestability provision
☐ guaranteed interest rate
☐ expense charges
☐ current interest rate
☐ tax treatment of rollovers*
☐ underwriting classification
☐ guaranteed cash values
☐ riders
☐ other ______

*The applicant should consult a qualified tax advisor regarding money rolled over from one policy to another.

The primary reason the new policy or contract is to be issued is (please be specific): ______

______

______

______

______ Name of Agent ______ Signature of Agent ______ Date

I hereby certify that I have considered the above information, and understand the effects of replacing my life insurance.

______ Name of Applicant ______ Signature of Applicant ______ Date

______ Address of Applicant ______ City ______ State ______ ZIP Code

Replacement Analysis Form

United of Omaha Life Insurance Company

Mutual of Omaha

Replacement Determination

Replacement of life insurance or an annuity policy is taking place if, following purchase of this new coverage, any existing coverage will be:

(1) lapsed, surrendered, partially surrendered, withdrawn upon, terminated, or assigned to the insurer
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2.	______	______	______	☐
3.	______	______	______	☐

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☐ suicide exclusion provision
☐ guaranteed death benefit
☐ surrender charge period and amount
☐ loan provision and loan interest rate
☐ face amount
☐ contestability provision
☐ guaranteed interest rate
☐ expense charges
☐ current interest rate
☐ tax treatment of rollovers*
☐ underwriting classification
☐ guaranteed cash values
☐ riders
☐ other ______

*The applicant should consult a qualified tax advisor regarding money rolled over from one policy to another.

The primary reason the new policy or contract is to be issued is (please be specific): ______

______

______

______

Name of Agent ______ Signature of Agent ______ Date ______

I hereby certify that I have considered the above information, and understand the effects of replacing my life insurance.

Name of Applicant ______ Signature of Applicant ______ Date ______

Address of Applicant ______ City ______ State ______ ZIP Code ______

Employer Owned Life Insurance Policies

Acknowledgement

Section 101(j) of the Internal Revenue Code ("IRC") became effective on August 18, 2006. This section provides that when an applicable policyholder (employer or related party) is the owner and beneficiary of a life insurance policy insuring the life of an employee, the death benefit may be taxable. This tax consequence can be avoided if the insured is a member of a class exempted from this treatment by IRC section 101(j) and notice and consent requirements have been satisfied.

It is the employer's responsibility to obtain appropriate tax and legal advice regarding the tax and legal consequences of death benefits paid for employer owned life insurance. This document is not intended to provide legal or tax advice.

Employer acknowledges that if the policy applied for is or may be employer owned as defined in IRC section 101, it may be required to obtain written consent from the insured employee prior to issuance of the life insurance policy. This consent should include, but may not be limited to, the following statements: (1) that the employee understands that life insurance on his or her life is being applied for by the employer and the maximum face amount of insurance for which the employee could be insured; (2) that the employee consents to being insured under such insurance; (3) that such insurance coverage may continue after the insured terminates employment from employer; and (4) that the employer will be the beneficiary of any proceeds payable upon the death of the employee.

Signature of Authorized Officer of Employer________________________________

Print Name ____

Position or Title __________________________ Date ________________

Employer Name ____

Employee/Insured's Printed Name __________________________________

PLEASE RETURN THE SIGNED ORIGINAL COPY TO UNITED OF OMAHA LIFE INSURANCE COMPANY AND LEAVE A COPY WITH THE EMPLOYER