Fixed Life Insurance Application – OR 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**

____

____

____

____

____

☐ **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 medical care, treatment for or been diagnosed with, 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 medical care, treatment for or been diagnosed with, 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: ______________________ (City) ______________________ (State) Date ______________

____
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 ______________ 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)

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

HIV Antibody Test
Information Form for Insurance Applicant

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and persons who have had sexual contact of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

The HIV Antibody Test

Before you consent to testing, please read the following important information.

1. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, your options for obtaining life and health insurance may be limited. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.
3. **Accuracy**. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
   (a) **False Positives:** the test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   (b) **False Negatives:** the test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4-12 weeks for a positive test result to develop after a person is infected.
4. **Possible Adverse Effects of Test.** A positive test result may cause you significant anxiety. A positive test result may limit your ability to obtain life, health, or disability insurance coverage in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A positive test result will be disclosed to you or the physician or county health department that you designate.
6. **Confidentiality**. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood, urine or oral specimen test may be reported to the Medical Information Bureau, a national insurance data bank, as a nonspecific abnormality determined by the testing of blood or oral specimen.
7. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information.** Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotline within the Portland area at 223-AIDS and outside the Portland area at 1-800-777-AIDS. Health insurance may be available through the Oregon Medical Insurance Pool for persons who are not otherwise able to obtain coverage. The telephone number for the Oregon Medical Insurance Pool is 1-800-542-3104 or 1-503-373-1692.

GIVE THIS COPY TO THE APPLICANT

Consent for Testing

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

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

To evaluate your eligibility for insurance, it is requested that you provide a sample of your blood, urine or an oral specimen for analysis. One of the tests to be performed will be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV). The HIV antibody test is actually a series of tests done by a medically accepted procedure.

I request that a final positive HIV result be reported to: (check one or more)

☐ 1. My physician ______________________________
Name

____
Address

____
City State

☐ 2. County health department

☐ 3. Myself directly

I voluntarily consent to the withdrawal of blood, urine or an oral specimen from me, and the testing of my sample or specimen for HIV antibodies. The consent is valid for six months from the date below.

____
Name of Proposed Insured (Print)

____
Date

____
Signature of Proposed Insured

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

MLU16805_1002

Consent for Testing

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

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

To evaluate your eligibility for insurance, it is requested that you provide a sample of your blood, urine or an oral specimen for analysis. One of the tests to be performed will be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV). The HIV antibody test is actually a series of tests done by a medically accepted procedure.

I request that a final positive HIV result be reported to: (check one or more)

☐ 1. My physician

Name ______________________

Address ______________________

City ______________ State ______________

☐ 2. County health department

☐ 3. Myself directly

I voluntarily consent to the withdrawal of blood, urine or an oral specimen from me, and the testing of my sample or specimen for HIV antibodies. The consent is valid for six months from the date below.

Name of Proposed Insured (Print) ______________________ Date ______________________

Signature of Proposed Insured ______________________

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

MLU16805_1002

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. You are urged to use this Guide in making a life insurance purchase.

This guide does not endorse any company or policy.

This Guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide How Much Life Insurance You Should Buy
- Decide What Kind of Life Insurance Policy You Need
- Compare the Cost of Similar Life Insurance Policies

L5846_0203

Buying Life Insurance

When you buy life insurance, you want a policy which fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance:

- Term insurance
- Whole life insurance
- Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance

Term insurance is death protection for a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy 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.

Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These 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 insurance 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 than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop “cash values” which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called “nonforfeiture benefits.” This refers to benefits you do not lose (or “forfeit”) when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance
An endowment insurance policy pays a sum or income to you — the policyholder — if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the “Surrender Cost Index” and the other is the “Net Payment Cost Index.” It will be worth your time to try to understand how these indexes are used, but in any event, use them ONLY for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What Is Cost?

“Cost” is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called “participating” policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called “guaranteed cost” or “non-participating” policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

- Premiums
- Cash Values
- Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

- Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
- Life Insurance Net Payment Cost Index. This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non-participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non-participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

- Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
- Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a "Shopper's Guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.
- Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
- In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.
- These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

Important Things To Remember — A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

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

Life Insurance and Annuity Suitability Information

Oregon

We appreciate your interest in your choice of a life insurance or an annuity policy from United of Omaha Life Insurance Company. Oregon requires that annuity and life insurance providers ask for information that will help determine whether the life insurance or annuity policy is suitable for your insurance objectives, financial situation, needs, age and other relevant information.

- ❑ I decline to complete the form. I assert that the ❑ life insurance ❑ annuity policy is suitable for my needs and insurance objectives. I have adequate income or available liquid assets to meet my financial situation and needs without using the money I am paying for in this policy. **(All owners must sign in the "Signatures" space at the bottom of the page.)**

Complete for all authorized signators on the policy.

Owner

Name ______________________

Address ______________________

____

City ____________ State ________ ZIP ________

Home Phone Number ______________________

Client ID/Social Security Number ______________________

Age Last Birthday ______________________

Marital Status Married ❑ Single ❑ Widowed ❑ Divorced ❑

Occupation ______________________

Joint Owner

Name ______________________

Address ______________________

____

City ____________ State ________ ZIP ________

Home Phone Number ______________________

Client ID/Social Security Number ______________________

Age Last Birthday ______________________

Marital Status Married ❑ Single ❑ Widowed ❑ Divorced ❑

Occupation ______________________

Dependent Information

Number of dependents ______________________

Ages of dependents ______________________

Financial Information

Annual Household Income ______________________

Liquid Net Worth (Excluding Residence) ______________________

Federal Tax Bracket ______________________

Years of Investment Experience

Investment Product	Years	Currently Own?
Stocks/Stock Mutual Funds		
Bonds/Bond Mutual Funds		
Annuities		
Life Insurance		
Certificates of Deposit		
Other		

Amount/Type of Product Being Purchased

❑ Term Life $_______ ❑ Permanent Life $ _______

❑ Annuity $_______ ❑ Other _______________ $ _______

Goals of this Product or Reason for Purchase

(Check all that apply)

❑ Preservation of Capital ❑ Future Income

❑ Wealth Accumulation ❑ Education Planning

❑ Tax Deferral ❑ Charitable Giving

❑ Immediate Income ❑ Provide Inheritance (Death Benefit)

Time Frame

When, if ever, do you anticipate withdrawing funds from this policy?

❑ 1 Year or Less ❑ 7-10 Years

❑ 1-3 Years ❑ 10 Years or More

❑ 3-7 Years ❑ Upon death (inheritance or charity)

Signatures

I/We have adequate income or available liquid assets to meet my/our financial obligations and emergency expenses without using the money I am using to purchase this life insurance or annuity policy.

✗ ______________________ Owner's Signature

✗ ______________________ Joint Owner's Signature

✗ ______________________ Agent's Signature

✗ ______________________ Agent's Print Name

Note to Producer: This form is required in addition to all replacement requirements if the sale of this life insurance policy or annuity involves a replacement.

L7229

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
(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 of Life Insurance or Annuities

United of Omaha Life Insurance Company

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

Premiums:

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

Policy Values:

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

Insurability:

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

If you are keeping the old policy as well as the new policy:

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

If you are surrendering an annuity or interest sensitive life product:

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

Other issues to consider for all transactions:

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

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

GIVE THIS COPY TO THE APPLICANT

Important Notice:
Replacement of Life Insurance or Annuities

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
☐ ATTN: Special Product Services: P.O. Box 2435, Omaha, NE 68103-2435

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

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

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

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

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

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

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

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

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

The existing policy or contract is being replaced because______________________________

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

______________________________ ______________________________
Applicant's Signature Printed Name/Date

______________________________ ______________________________
Producer's Signature Printed Name/Date

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

Important Notice:
Replacement of Life Insurance or Annuities

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
☐ ATTN: Special Product Services: P.O. Box 2435, Omaha, NE 68103-2435

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

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

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

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

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

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

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

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

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

The existing policy or contract is being replaced because____

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

____________________________ ____________________________
Applicant's Signature Printed Name/Date

____________________________ ____________________________
Producer's Signature Printed Name/Date

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

Fixed Life Replacement Sales Material Checklist

Required for all Fixed Life replacement sales.

Applicant Name: ______________________________________

Agent Name:____

Date: ____

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

Item	Description	Form Number – list series # if applicable	Check Box
Life Financial Report	Brochure	MLC25961_	
Life Product Line	Brochure	LC4227_	
Life Time Protection	Brochure	LC1975_	
Legacy SPL	Brochure	LC5576_	
Legacy SPL	Highlight Sheet	LC5575_	
Term Life Express	Brochure	LC5959_	
Term Life Express	Highlight Sheet	LC5960_	
Term Life Complete	Brochure	LC5962_	
Term Life Complete	Highlight Sheet	LC5963_	
Mortgage Term Plus	Brochure	LC5494_	
Mortgage Term Plus	Highlight Sheet	LC5493_	
Priority AccumUL	Highlight Sheet	LC4884_	
Guaranteed Universal Life Express & Complete	Brochure	LC6217_	
Guaranteed Universal Life Express	Highlight Sheet	LC6354_	
Guaranteed Universal Life Complete	Highlight Sheet	LC6353_	
Priority Max GUL	Highlight Sheet	LC4721_	
Priority Term 10, 15, 20 & 30	Highlight Sheet	LC4088_	
**All Other Materials Used:* Please list item, description and form number (if any),			

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

L6586_0407

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