

Fixed Life Insurance Application – WA 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	Spouse
<input type="checkbox"/> Client Profile Interview	<input type="checkbox"/> Client Profile Interview
<input type="checkbox"/> Oral Fluid Test	<input type="checkbox"/> Oral Fluid Test
<input type="checkbox"/> Blood Profile	<input type="checkbox"/> Blood Profile
<input type="checkbox"/> Urinalysis	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Physical Data	<input type="checkbox"/> Physical Data
<input type="checkbox"/> Long Form Exam	<input type="checkbox"/> Long Form Exam
<input type="checkbox"/> EKG	<input type="checkbox"/> EKG
<input type="checkbox"/> Treadmill EKG	<input type="checkbox"/> Treadmill EKG
<input type="checkbox"/> Chest X-ray	<input type="checkbox"/> Chest X-ray
<input type="checkbox"/> Inspection Report	<input type="checkbox"/> Inspection Report
<input type="checkbox"/> MD Exam	<input type="checkbox"/> 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: Option 1: Accumulation Value Included in Specified Amount
(Universal Life Only) 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?
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

- 1** Name, address and telephone number of personal physician of the Proposed Primary Insured: _____

- (a) Date last seen: _____ (b) State reason, findings and treatment: _____

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

- (a) Date: _____ (b) State reason, findings and treatment: _____

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

- 3** Have you **ever** (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek care or treatment for, or (c) consulted with a health care provider regarding: **Yes No**
- (a) Any disease or abnormal condition of the heart, circulatory system or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease or murmur, coronary artery blockage, chest pain, or stroke/ministroke?
- (b) Any disease of the lungs or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema or shortness of breath?
- (c) Any digestive system disease, including ulcer, abdominal or stomach pain, liver or gallbladder disease, hepatitis, cirrhosis, colitis or other colon, intestinal or rectal disorder?
- (d) Any urinary or reproductive system disease including protein, blood or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor or disease of the prostate, testis, breasts, uterus or ovaries?
- (e) Any brain, nerve or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?
- (f) Any bone or joint disorder, arthritis or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia or other bodily deformity, amputation, back or spinal disorder?
- (g) Any disease or disorder of vision or hearing?
- (h) Cancer, tumor, blood/bleeding disorder, diabetes, thyroid or other glandular/metabolic disorder?
- 4** Have you **ever** been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider?
- 5** During the **last 10 years**, have you:
- (a) had any illness, injury, surgery, hospitalization, medical examination or care not listed above?
- (b) had or received treatment for any unexplained fever, weight loss, fatigue or chronic cough?
- (c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test?
- (d) been advised by a physician to have a surgical operation or procedure otherwise not listed?
- 6** Are you pregnant?
- Enter approximate delivery date: _____
- Any complications with this pregnancy or previous pregnancies?
- 7** During the **last 12 months**, have you lost more than 10 pounds?
- 8** During the **last 2 years**, have you, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication?

(If “Yes,” to question 8 (a), (b) or (c), please list details below.) If more space is needed, use Section I.

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

Section E Underwriting Information — Proposed Primary Insured (continued)

- 9** During the **last 10 years**, have you: **(If answered “Yes” please list details in Section F)**
- (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? **Yes** **No**
 - (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:
- (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).**
- (a) ever been declined, postponed, limited, denied reinstatement or asked to pay an extra premium by any insurance company? **Yes** **No**
 - (b) engaged in any hazardous sports or activities such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, skydiving, skin diving or scuba diving 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.

	Spouse		Child(ren)	
	Yes	No	Yes	No
3 Has the Spouse/Child(ren) ever (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek care or treatment for, or (c) consulted with a health care provider regarding:				
(a) Any disease or abnormal condition of the heart, circulatory system or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease or murmur, coronary artery blockage, chest pain, or stroke/ministroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Any disease of the lungs or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Any digestive system disease, including ulcer, abdominal or stomach pain, liver or gallbladder disease, hepatitis, cirrhosis, colitis or other colon, intestinal or rectal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Any urinary or reproductive system disease including protein, blood or sugar in the urine; tumor, cysts, infection or failure of the kidney; tumor or disease of the prostate, testis, breasts, uterus or ovaries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Any brain, nerve or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Any bone or joint disorder, arthritis or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia or other bodily deformity, amputation, back or spinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Any disease or disorder of vision or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Cancer, tumor, blood/bleeding disorder, diabetes, thyroid or other glandular/metabolic disorder?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) had or received treatment for any unexplained fever, weight loss, fatigue or chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) been advised by a physician to have a surgical operation or procedure otherwise not listed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Is spouse/child(ren) pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enter approximate delivery date: _____				
Any complications with this pregnancy or previous pregnancies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 During the last 12 months has the Spouse/Child(ren) lost more than 10 pounds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(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)

- 9** During the **last 10 years**, has the Spouse/Child(ren):
(If you answered “Yes” please list details in Section H)
- | | | | |
|---|--------------------------|--------------------------|---|
| | Spouse | | Child(ren) |
| | Yes | No | 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (c) been or are you currently a member of Alcoholics Anonymous or Narcotics Anonymous? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
- 10** During the **last 10 years** has the Spouse/Child(ren) proposed for insurance used:
- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| (a) any form of tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) any form of nicotine replacement therapy (for example — nicotine gum, patch, or spray?) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 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

- 11 Has the Spouse/Child(ren) proposed for insurance:**
(If answered “Yes,” please list details in Section I)
- | | | | |
|--|--------------------------|--------------------------|---|
| | Spouse | | Child(ren) |
| | Yes | No | Yes No |
| (a) ever been declined, postponed, limited, denied reinstatement or asked to pay an extra premium by any insurance company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (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?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (c) any intention of traveling or living outside the USA or Canada in the next two years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <i>(If “Yes,” complete Foreign Travel Questionnaire.)</i> | | | |
| (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.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (e) within the last 5 years: (1) been convicted of two or more moving violations, or (2) been convicted of driving under the influence of alcohol or drugs, or (3) had a driver’s license suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (f) been convicted of a felony within the last 10 years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (g) been on probation within the last 12 months or are you currently on probation?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (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?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

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

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 **It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

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

Signed at: _____ Date _____
City State

Signature of Proposed Primary Insured (Age 15 and Over)

Signature of Spouse (if a Proposed Insured)

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

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

- 10 In addition to the above Agreement, has the Proposed Insured informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? Yes No
- 11 Do you, the Producer(s), know or have reason to believe that the policy applied for has replaced or will replace any existing life insurance policy(ies) and/or annuity contract(s)? Yes No If "Yes," the Producer shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.
- 12 Did you, the Producer(s), give the Proposed Primary Insured the MIB Group, Inc. Pre-Notice, the Fair Credit Reporting Act Disclosure Statement, the Notice of Information Practices, the Investigative Consumer Reports Notice, the Summary of Rights Under the Fair Credit Reporting Act and the Life Insurance Buyer's Guide? Yes No (If "No," explain.) _____
- 13 In the presence of the Proposed Primary Insured/Spouse have you asked each question exactly as written and recorded the answers completely and accurately? Yes No (If "No," explain.) _____

Signature of Producer

Date

Print or Stamp Producer Name

Signature of Producer

Date

Print or Stamp Producer Name

**Appendix 1 - Authorization To Disclose Personal Information To
United of Omaha Life Insurance Company**

Meanings of Terms

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

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

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

“Specified Companies” means:

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

Authorization to Disclose

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

Purposes

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

Potential For Redisclosure

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

Failure to Sign

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

Expiration and Revocation

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

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

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

Copy

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

Names and Signatures

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

Printed Name of Proposed Insured _____ Spouse’s Printed Name _____ If children are to be insured, their printed names _____
(If Proposed Insured)

Signature of Proposed Insured _____ Signature of Spouse _____ Signature of Parent or Guardian _____
(If Proposed Insured)

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): _____

_____	_____
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



The Accelerated Benefit offered under this rider is intended to qualify for favorable tax treatment under Section 101(g) of the Internal Revenue Code of 1986, as amended by Public Law 104-191. When the Accelerated Benefit is paid under the terms of this rider, the life insurance policy to which this rider is attached will terminate.

If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.

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 24 months or less from the date a physician signs the statement of proof of Terminal Illness.

The Accelerated Benefit amount will equal:

- (a) 88% of the net death benefit of the policy; plus
- (b) 88% 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



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If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.

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.

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I acknowledge receipt of this Disclosure Form.

Applicant Signature

Date

I have provided this Disclosure Form to the Applicant.

Producer Signature

Date

HIV Test Informed Consent Form



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

To evaluate your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood and/or other bodily fluids for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test results. A series of tests will be performed by a licensed laboratory using a medically accepted procedure.

Meaning of Test Results

The test is not for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. Positive test results do not mean you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive test results may cause you significant anxiety. It will also adversely affect your insurance application.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on their behalf or to outside legal counsel who needs such information to effectively represent them in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. A generic code which signifies only a nonspecific test abnormality may be reported to the Medical Information Bureau (MIB, Inc.), if the results are other than normal.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are positive or indeterminate, you are entitled to that information. However, because a trained person should deliver that information so that you can understand clearly what the test results mean, you are asked to list a health care provider or health care agency so that they may tell you the result, explain its meaning and provide post-test counseling.

Name of Physician/Health Care Agency _____

Address _____

If you do not identify a health care provider or health care agency to receive the positive or indeterminate results, the insurer is required by law to provide the test results to the local health department for interpretation and post-test counseling. Washington law requires post-test counseling and prohibits sending positive or indeterminate results directly to you.

Consent

I have read and I understand this Informed Consent Form. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of my blood and/or other bodily fluids for HIV antibodies, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date _____

Signature of Proposed Insured

Signature of Agent/Witness

HIV Test Informed Consent Form



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

Signature of Proposed Insured

Signature of Agent/Witness

Life Insurance Buyer's Guide



Prepared by the National Association of Insurance Commissioners

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

This guide does not endorse any company or policy.

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

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

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

Important Things to Consider

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

Buying Life Insurance

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

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

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

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

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

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

What About the Policy You Have Now?

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

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

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

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

How Much Do You Need?

Here are some questions to ask yourself:

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

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

What is the Right Kind of Life Insurance?

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

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

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

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

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

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

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

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

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

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

Life Insurance Illustrations

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

Finding a Good Value In Life Insurance

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

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

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

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

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

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

Important Notice Regarding Replacement of Life Insurance



United of Omaha Life Insurance Company

- ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
 - ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
 - ATTN: Special Product Services: P.O. Box 2435, Omaha, NE 68103-2435
-

(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one — or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

Statement to Applicant by Agent or Broker

(Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?
 No Yes, explain:

2. Are there penalties, set-up or surrender charges for the new policy?
 No Yes, explain, emphasizing any extra cost for early withdrawal:

3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?
 No Yes, explain:

4. Are there adverse tax consequences from the replacement under current tax law?
 No Yes, explain:

5. (a) Are interest earnings a consideration in this replacement?
 No Yes
(b) If “Yes,” explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings and the reduction of earnings that may result from set-up charges, policy fees and other factors.

6. Are minimum amounts required to be on deposit before excess interest will be paid?
 No Yes, explain:

Important Notice Regarding Replacement of Life Insurance



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6. Are minimum amounts required to be on deposit before excess interest will be paid?
 No Yes, explain:

7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
- (a) Are the interest rates quoted before ____ or after ____ fees and mortality charges have been deducted?
 - (b) Interest rates are guaranteed for how long? _____
 - (c) The minimum interest rate to be paid is how much? _____
 - (d) If applicable, the rate you pay to borrow is _____, and the limit on the amount that can be borrowed is _____.
 - (e) The surrender charges are _____.
 - (f) The death benefit is _____.

8. Are there other short- or long-term effects from the replacement that might be materially adverse?

- No Yes, explain:

Signature of Agent or Broker

Date

Name of Agent or Broker
(Print or Type)

Address

List of Policies or Contract to be Replaced

Company	Insured	Contract No.
---------	---------	--------------

CAUTION: The insurance commissioner suggests you consider these points.

Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.

Termination or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.

You are entitled to advice from the existing agent or company. Such advice might be helpful.

Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received _____
Applicant's Signature
Date

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CAUTION: The insurance commissioner suggests you consider these points.

Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.

Termination or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.

You are entitled to advice from the existing agent or company. Such advice might be helpful.

Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received _____
Applicant's Signature
Date

This completed form should be filed permanently with your new insurance policy.

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