UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL of OMAHA COMPANY

CALIFORNIA – APPLICATION FOR LIFE INSURANCE

FULLY UNDERWRITTEN PRODUCTS – ONE BASE POLICY PER APPLICATION

✍ *Checklist for Submitting a Complete 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

☞ PLEASE USE THE PRECISE PRODUCT AND PLAN ON THE APPLICATION TO AVOID APP AMENDS

❑ **UNIVERSAL LIFE PRODUCT NAMES:**
- AccumUL Plus • AccumUL Answers
- Guaranteed Universal Life Survivor
- Guaranteed Universal Life • Guaranteed Universal Life Plus

❑ **UNIVERSAL LIFE RIDER NAMES:**
- Disability Rider
- Children's Rider
- Guaranteed Insurability Rider
- Accidental Death Benefit Rider

❑ **ACCUMUL PLUS AND ACCUMUL ANSWERS ONLY:**
- Additional Insured Rider Self • Additional Insured Rider Spouse
- Additional Insured Rider Other Insured

❑ **Guaranteed Universal Life SURVIVOR ONLY:**
- Four Year Level Term Insurance Rider
- For 2nd Insured – Place their information in PART 1A PAGE 2 of 2 in section "RIDER ON OTHER PROPOSED INSURED"

❑ **TERM PRODUCT NAMES:**
- Term Life Answers

❑ **TERM LIFE RIDER NAMES:**
- Waiver of Premium
- Accidental Death Benefit Rider
- Children's Rider
- Other Insured Rider

✎APPLICATION SUBMISSION GUIDELINES

❑ Attach a cover letter or additional information as needed, AND Always submit the Producer Statement and Producer Report page
❑ Always obtain signed HIPAA/MIB authorization
❑ Always provide client with MIB Inc Pre-Notice, Notice of Information Practices, Investigative Consumer Reports Notice, Summary of Rights, and Life Insurance Buyer's Guide
❑ All changes should be initialed by the Applicant / Owner
❑ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client
❑ If selecting the Disability Continuation of Planned Premium Rider, Accidental Death Benefit Rider, Children's Rider, Additional Insured Rider or the Other Insured Rider, a **RIDER AMOUNT** must be entered on the application.

✎IMPORTANT FORMS

❑ Replacement Notice – If applicable, the client must sign and retain a copy for their records
❑ Payment Authorization – Complete this form if applicable
❑ Complete two copies of the TIA form and leave the unsigned copy with the applicant when: a) all 6 questions on the TIA are answered "no"; and b) a check or electronic transaction authorization for the initial premium is collected. **DO NOT** collect a check if any of the 6 TIA questions are answered "yes" - a completed electronic transaction authorization may still be submitted. **DO NOT** complete the TIA if initial payment won't be collected until issue.
❑ You will need a signed Accelerated Death Benefit Rider Disclosure Form – Unless applying for Guaranteed Universal Life Survivor at any face amount
❑ If face amount is $100,000 or over, you will need a signed HIV consent form (If your state does not require the HIV Consent form then this form will not be included in this application package)
❑ If face amount is $1,000,000 and above and the Proposed Insured is age 65, or over you will need: (a) signed Statement of Policyowner form and, (b) signed Premium Funding and Acknowledgement form

✎Supplemental Applications, Forms and Buyer's Guide:

- ***Child(s) Rider Supplemental Application:*** If applying for the children's rider complete the Child(s) Rider Supplemental Application
- ***Juvenile Life Insurance Supplemental Application:*** If applying for life insurance for proposed insured ages 0-17 years
- ***Acknowledgment/Illustration Certification form:*** Required when no illustration was used at point of sale, or the policy applied for is other than as shown in the illustration, or a computer screen illustration was displayed at point of sale but no hard copy was furnished
- ***1035 Exchange:*** By exercising a 1035 (a) exchange, the client may transfer the money from the old carrier to United of Omaha without incurring a taxable gain for federal income tax purposes
- ***Buyer's Guide:*** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale

PARAMEDICAL VENDORS	✎INDICATE UNDERWRITING REQUIREMENTS INITIATED OR, COMPLETED ON THE PROPOSED INSURED(S)	
APPS – 1-800-635-1677 **EMSI** – 1-800-872-3674 **EXAMONE** – 1-877-933-9261 **PORTAMEDIC** – 1-800-765-1010 **SUPERIOR MOBILE MEDICS** – 1-800-898-3926	**Primary Proposed Insured** ☐ Blood Profile ☐ Physical Data ☐ Urinalysis ☐ Long Form Exam ☐ MD Exam ☐ Treadmill EKG ☐ EKG	**Other Proposed Insured:** ☐ Blood Profile ☐ Physical Data ☐ Urinalysis ☐ Long Form Exam ☐ MD Exam ☐ Treadmill EKG ☐ EKG

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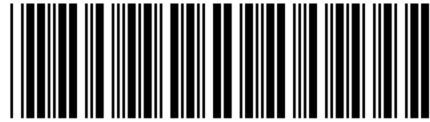
A MUTUAL *of* OMAHA COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175



PART 1A, PAGE 1 OF 2 LIFE INSURANCE APPLICATION

PROPOSED INSURED

Proposed Insured Legal Name ____________________

Gender ☐ Male ☐ Female Height ______ Weight _______ Social Security No. ____________________

Date of Birth ____________________ State of Birth ____________ Annual Income ____________________

Driver's License No ____________________ Driver's License State ______

Legal Residence Address ____________________
Street City ST ZIP

Best Time to Call ______ Phone No. ____________________ E-mail ____________________

Occupation/Duties ____________________ Employer ____________________

IF PROPOSED INSURED IS AGE [0-17], COMPLETE JUVENILE SUPPLEMENTAL APPLICATION

PLAN INFORMATION

Product Name ____________________ Amount of Insurance Applied for $ ____________________

Risk/Rate Class Applied For:

☐ Standard or Best Available Risk Class

☐ Substandard Risk Class Proposed: Table ____________________

☐ UL Option 1 Level Death Benefit ☐ UL Option 2 Specified Amount plus Accumulation Value

☐ Term Period __________ years ☐ Return of Premium Term

Rider Name	Rider Amount

Payment Mode ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft ☐ Other ____________

Modal Premium $____________________ Collected Premium $____________________

OWNER

Complete Policyowner information if Proposed Insured is not the Policyowner

Name of Policyowner ____________________ Date of Birth ____________________

Relationship to Proposed Insured______________ Social Security No./Tax ID ____________________

Citizenship Country ____________________ Phone No. ____________________

Policyowner Address ____________________
Street City ST ZIP

Secondary Addressee – Optional. This person will receive copies of overdue premium and lapse notices.

Name ____________________Phone No. ____________________

Mailing Address ____________________
Street City ST ZIP

If more space is needed, provide information in Comments section.

BENEFICIARY

Primary Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

Contingent Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

If more space is needed, provide information in Comments section.

OTHER COVERAGE INFORMATION

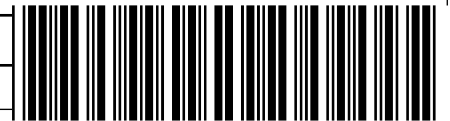
1. Have you or any person proposed for insurance been offered cash, or any other consideration for obtaining this policy? ☐ Yes ☐ No
2. Are you or any Proposed Insured planning to enter into a finance arrangement to pay any premium payments due under this policy? ☐ Yes ☐ No
3. Do you or any person proposed for insurance intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? ☐ Yes ☐ No
   If "Yes" to questions 1, 2 or 3, provide information in Comments section.
4. List below all life insurance policies and/or annuity contracts on any person proposed for insurance that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt.)
   If none, check the following box. ☐ **None**
5. Has any person proposed for insurance had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? ☐ Yes ☐ No
   Please complete the box(es) below.
   The Producer shall comply with any additional state, and/or Company replacement requirements.

Company	Policy or Contract Number	Face Amount	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
					☐ Yes ☐ No	☐ Yes ☐ No	
					☐ Yes ☐ No	☐ Yes ☐ No	
					☐ Yes ☐ No	☐ Yes ☐ No	
					☐ Yes ☐ No	☐ Yes ☐ No	
					☐ Yes ☐ No	☐ Yes ☐ No	

COMMENTS

Provide any additional information necessary and the details of "Yes" answers. Always identify question number.

____



RIDER ON OTHER PROPOSED INSURED

Other Proposed Insured Legal Name ______

Gender ☐ Male ☐ Female Height ______ Weight ______ Social Security No. ______

Date of Birth ______ State of Birth ______ Annual Income ______

Driver's License No ______ Driver's License State ______

Legal Residence Address ______

Best Time to Call ______ Phone No. ______ E-mail ______

IF OTHER PROPOSED INSURED IS AGE 0-17, ALSO COMPLETE JUVENILE SUPPLEMENTAL APPLICATION

Occupation/Duties ______ Employer ______

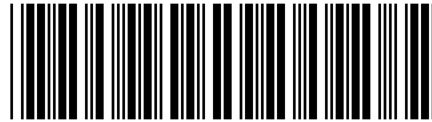
Primary Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

Contingent Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

If more space is needed, provide information in Comments section

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175



PART 1B, PAGE 1 OF 1 LIFE INSURANCE APPLICATION

NON-MEDICAL UNDERWRITING

	Proposed Insured	Other Proposed Insured Rider
1. Are the persons proposed for insurance citizens of the United States? . . . . **If "No," complete the Foreign National questionnaire.**	☐ Yes ☐ No	☐ Yes ☐ No
2. Has any person proposed for insurance ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy? . . . . **If "Yes," to question 2, please list details below.**	☐ Yes ☐ No	☐ Yes ☐ No

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

	Proposed Insured	Other Proposed Insured Rider
3. Has any person proposed for insurance **If answered "Yes," please list details in the Comments section.**		
(a) had life insurance coverage declined, postponed, or limited, or been denied reinstatement, or asked to pay extra premium by any insurance company?	☐ Yes ☐ No	☐ Yes ☐ No
(b) engaged in any hazardous sports, or activities within the last three years, such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, skydiving, skin diving or scuba diving, cliff diving, base jumping or bungee jumping, or plan such activity in the next two years? . . . . **If "Yes," complete the appropriate questionnaire.**	☐ Yes ☐ No	☐ Yes ☐ No
(c) any intention of traveling, or living outside the USA, or Canada in the next two years? **If "Yes," complete the Foreign Travel questionnaire.**	☐ Yes ☐ No	☐ Yes ☐ No
(d) flown as a civilian pilot, student pilot, or crew member within the last three years, or plan such activity in the next two years? . . . . **If "Yes," complete the Aviation questionnaire.**	☐ Yes ☐ No	☐ Yes ☐ No
(e) within the last five 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?	☐ Yes ☐ No	☐ Yes ☐ No
(f) been convicted of a felony, or have been incarcerated within the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No
(g) been on probation within the last 12 months, or are currently on probation?	☐ Yes ☐ No	☐ Yes ☐ No

FINANCES

4. Has any person proposed for insurance ever filed for bankruptcy? . . . . ☐ Yes ☐ No | ☐ Yes ☐ No

If "Yes," please provide type(s) and date(s) ____________________

5. What is the purpose of this insurance (e.g., income replacement, mortgage protection, key person, buy-sell)?

____

6. If applying for $500,000 or more, complete box(es) below.

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

FAMILY HISTORY

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

	Age at Death	**Age at Death**	**If Living, Present Health – If Deceased, Cause of Death**	
	Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				

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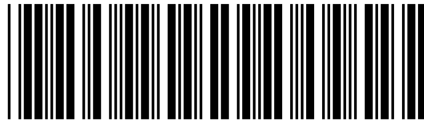


PART 2, PAGE 1 OF 3 LIFE INSURANCE APPLICATION

MEDICAL UNDERWRITING

Question	Proposed Insured	Other Proposed Insured Rider
1. Does any person proposed for insurance currently have a personal physician?	☐ Yes ☐ No	☐ Yes ☐ No

Person Proposed for Insurance	Name, Address and Telephone Number of Personal Physician	Date last seen	State Reason, Findings and Treatment

Question	Proposed Insured	Other Proposed Insured Rider
2. Has any person proposed for insurance ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or health care provider?	☐ Yes ☐ No	☐ Yes ☐ No
3. Has any person proposed for insurance ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment 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/mini-stroke?	☐ Yes ☐ No	☐ Yes ☐ No
(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, or shortness of breath?	☐ Yes ☐ No	☐ Yes ☐ No
(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?	☐ Yes ☐ No	☐ Yes ☐ No
(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?	☐ Yes ☐ No	☐ Yes ☐ No
(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	☐ Yes ☐ No	☐ Yes ☐ No
(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?	☐ Yes ☐ No	☐ Yes ☐ No
(g) any disease, or disorder of vision, or hearing?	☐ Yes ☐ No	☐ Yes ☐ No
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/metabolic disorder?	☐ Yes ☐ No	☐ Yes ☐ No
4. In the past 10 years, has any person proposed for insurance		
(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a physician, or other health care provider?	☐ Yes ☐ No	☐ Yes ☐ No
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	☐ Yes ☐ No	☐ Yes ☐ No
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous?	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 12 months, has any person proposed for insurance:		
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?	☐ Yes ☐ No	☐ Yes ☐ No
(b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy?	☐ Yes ☐ No	☐ Yes ☐ No
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	☐ Yes ☐ No	☐ Yes ☐ No
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL UNDERWRITING

6. In the past two years, has any person proposed for insurance, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? . . . . ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

If answered "Yes," please list details below.
If more space is needed use the Comments section.

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

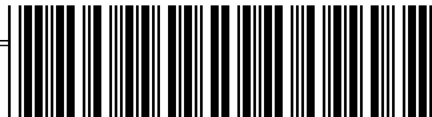
7. In the past five years, has any person proposed for insurance consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? . . . ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

If answered "Yes," please list details below.
If more space is needed use the Comments section.

Person Proposed for Insurance	Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

COMMENTS

List details of "Yes" answers. Identify question number and circle applicable items: Include diagnosis, dates, prescription medications, duration, and names and addresses of all attending physicians and medical facilities. Use additional sheet of paper if necessary.



AGREEMENT

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

1. All answers in this application are true and complete, to the best of my knowledge and belief, and will be relied on by United of Omaha to determine insurability. The statements and answers in the application are the basis for any policy issued by United of Omaha, and no information about them will be considered to have been given to United of Omaha unless it is stated in the application. Any incorrect or misleading answers may void this application and any issued policy effective the issue date.
2. If mode of payment is Bank Service Plan, I/We authorize premiums due to be automatically paid to United of Omaha, by electronic fund transfer until this authorization is cancelled in writing.
3. Until this application is approved for issue by United of Omaha's Underwriting Department, no policy will be issued and no coverage will be provided except by a Temporary Insurance Agreement, if provided. In no event will benefits be paid for the same loss under both a Temporary Insurance Agreement and any policy issued from this application.
4. The issue date of the policy will be the date shown in the policy, even though coverage may not become effective until a later date. Coverage under the issued policy will become effective only if and when: (a) the full initial premium is paid or, if paid by electronic funds transfer, the full initial premium is received by United of Omaha, (b) United has been notified of any change in either the health or habits of any person proposed for insurance between the date the application is approved for issue and the date the policy is delivered, and (c) the policy is delivered and all delivery requirements (including a signed good health statement if required) are completed during the lifetime of the Proposed Insured.
5. If, prior to policy delivery, any person proposed for insurance dies, or there has been a change in that person's health or habits that will change any statement or answer to any question in the application, we will immediately notify United of Omaha. If the person proposed for insurance is not eligible for the insurance applied for, we agree that no policy of any kind will be in effect.
6. I have received the MIB Group, Inc. Pre-Notice, the Notice of Information Practices, and a Life Insurance Buyer's Guide before completing this application.
7. If the applicant is other than the person proposed for insurance, the applicant will own the policy.
8. No Producer can: (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.
9. **Fraud Warning:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

The application includes Parts IA, Part 1B, Part 2 and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application, by attaching as part of any policy delivered to the Owner.

I have read and understand the Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB"), the Authorization to Disclose Personal Information to United of Omaha Life Insurance Company and the Agreement Section, and I approve all my answers as recorded in this application.

Signed at: ____________________ City ______ State Date ______________ Mo Day Yr

____
Signature of Proposed Insured age 15 and Over

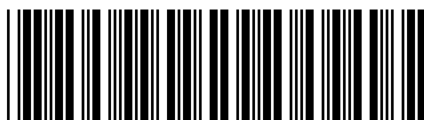
____
Signature of Applicant/Owner/Trustee if other than Proposed Insured **or** if the Owner is a corporation, trust, or other entity. Include title of Signee(s).

____
Signature of Other Proposed Insured age 15 and Over

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

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

____
Signature of Parent or Guardian if Proposed Insured is under Age 15



United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Producer Statement

1. Has any person proposed for insurance informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? . . . . ☐ **Yes** ☐ **No**
   If "Yes," give name(s) of the person(s) ____

   ____

2. Do you, the Producer(s), know or have reason to believe that the policy(ies) applied for has replaced or will replace any existing life insurance policies or annuity contracts? . . . . ☐ **Yes** ☐ **No**
3. Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer's Guide and comply with all state and Company replacement requirements? ☐ **Yes** ☐ **No** **If "No," please explain** ______________________

   ____

   ____

4. I/We certify that during an interview with the Proposed Insured, I/We asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ☐ **Yes** ☐ **No**
   If "No," please explain ____

   ____

   ____

5. I conducted said interview in person ☐ **Yes** ☐ **No** **If "No," please explain** ______________________

   ____

   ____

______________________________ ______________ ______________
Signature of Producer # 1 Production Number Mo Day Yr

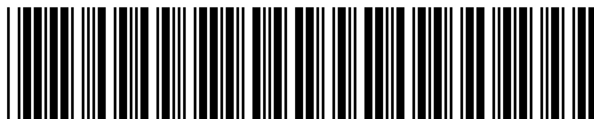
______________________________ ______________ ______________
Signature of Producer # 2 Production Number Mo Day Yr

____
Print or Stamp Producer #1 Name

____
Print or Stamp Producer #2 Name

______________________________ ______________________________
General Agent/General Manager Name General Agent/General Manager Stamp

C997LNA09A **PLEASE SUBMIT ALL PAGES**



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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(s) ________________

____

3 Are you related to the Proposed Primary Insured or Owner? ❑ Yes ❑ No If answered "Yes," state relationship __________

4 How long have you known the Proposed Primary Insured? ________________

5 How long have you known the Proposed Owner? ________________

6 Have you, the producer, observed or are you aware of any additional information that may affect the issuance of this policy?

If "Yes," explain below ❑ **Yes** ❑ **No**

____

____

____

7 Will any entity other than a life insurance company evaluate the Proposed Life Insured(s) medically to determine life expectancy or to otherwise obtain financing? ❑ Yes ❑ No If "Yes," provide details ________________

____

____

____

8 Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? ❑ Yes ❑ No

9 Rate class quoted ________________

10 Please check the Underwriting requirements ordered: ❑ Blood Profile/HOS ❑ Inspection Report ❑ MD Exam ❑ Treadmill EKG ❑ EKG ❑ Paramedical Exam Paramed Company ________________

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

Address	From	To

Additional Comments

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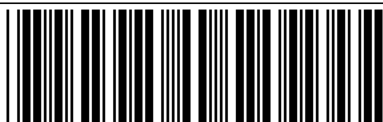

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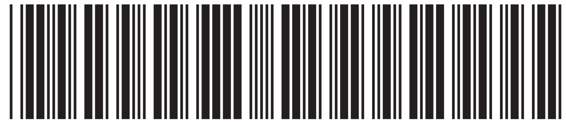
UNITED OF OMAHA LIFE INSURANCE COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600



PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: ____________________________ Policy Number(s) if known: ____________________________

Complete this form only when authorizing a bank account withdrawal for premium payment.

PAYMENT INFORMATION

1. **Initial Monthly Premium Payment (select only one option)** Amount Quoted $__________________________
   - ☐ Draft premium immediately upon approval/issue
   - ☐ Draft initial premium on or after: _______/_______/_______ (Please Note: If policy issue is after date selected, premium will be withdrawn on the policy issue date or receipt of delivery requirements)
   - ☐ Check collected and mailed to Mutual of Omaha

   When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT AS STATED ABOVE. The first Withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. We **CANNOT** establish electronic payments from foreign banks.

2. **Ongoing Premium Payments**- Automated Bank Account Withdrawal (Monthly)
   Specify the date ongoing premiums will be withdrawn: (1st through the 28th of each month) ____________________
   Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

PAYOR INFORMATION

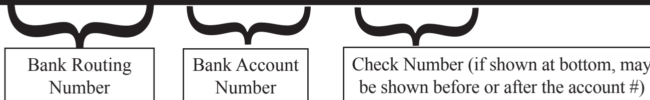
Name of payor as shown on bank account: ______________________________ Social Security No.__________________

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/ Insured by selecting one of the following. (Additional documentation required)

- ☐ Employer
- ☐ Business owned by Proposed Insured/Insured or spouse
- ☐ Power of Attorney or legal guardian
- ☐ Living Trust
- ☐ Other ____________________________________

ACCOUNT INFORMATION

1. Account Type (check one): ☐ Checking ☐ Savings
2. Name of Financial Institution: ____
3. Complete information below or attach a voided check here.
   Bank Routing Number: ___________________________ Bank Account Number: ___________________________
   (Do not use Debit/Credit Card numbers)



Bank Routing Number | Bank Account Number | Check Number (if shown at bottom, may be shown before or after the account #)

AUTHORIZATION

I authorize United of Omaha Life Insurance Company ("United of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to United of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, United of Omaha may require written confirmation from me within 14 days after my verbal notice.

Date _________________________ X ____
Mo./Day/Yr. Authorized Signature as Shown on Account

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB Inc., state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me and my children, if they are proposed insureds (My Children), to release Personal Information about me or My Children to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

The Personal Information will be used to determine my and My Children's eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual, or its reinsurers, to disclose my and My Children's personal Information to MIB, Inc. I understand that my and My Children's Personal Information received by MIB, Inc. 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 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 be redisclosed without the protection of the federal privacy regulations.

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

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Proposed Insured acknowledges and agrees that if there is more than one Proposed Insured on this application, all information provided may be reviewed or shared with the other Proposed Insured. A completed and signed application will become part of each insured's policy.

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

____

____________________ **Date:** ____________________
Signature of Proposed Insured Mo Day Yr

____________________ **Date:** ____________________
Signature of Spouse (if Proposed Insured) Mo Day Yr

____________________ **Date:** ____________________
Signature of Parent or Guardian (if Proposed Insured is a Minor) Mo Day Yr

____________________ **Date:** ____________________
Signature of Non-minor Child (if Proposed Insured is a Non-minor) Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Third Party Notice Request Form

You have the right to designate a person, in addition to yourself, to receive notice that your premium is past due and has not been paid. This notice will be sent at least 30 days prior to the effective date of cancellation of your policy or certificate. This notice will state the amount of premium, the date by when the premium must be paid to avoid policy cancellation and the date on which coverage terminates.

You can designate this additional person to receive notice of nonpayment now or at a later time, provided the policy is in force, and you give us written notice containing the additional person's name, address and phone number.

You have the right to change this third-party designation at any time; however, you must submit the change in writing to the address below.

Please Complete Either Section 1 or Section 2 And Return To Us.

Section 1

I wish to designate an additional person to receive notice of nonpayment of premium.

Policyowner/Certificateholder: ______________________________

Policy Number: ____________________ Date: ____________

Third Party: ______________________________
(Please print name of other person to receive notice of nonpayment)

Third Party Address: ______________________________
(Street Address) (City) (State) (ZIP)

Third Party Phone: (______) ____________
(Area Code) (Number)

Signature of Policyowner/Certificateholder

____

Date ______________________________

Section 2

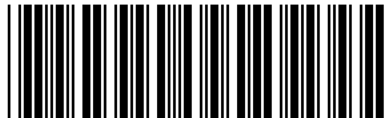
I do not wish to designate an additional person to receive notice of nonpayment of premium.

Signature of Policyowner/Certificateholder

____

Date ______________________________

Direct all correspondence to: United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175



L8524

Temporary Life Insurance Agreement ("Agreement")

United of Omaha Life Insurance Company ("United", "we", "our", "us"), Mutual of Omaha Plaza, Omaha, NE 68175

If any proposed insured dies while coverage under this agreement is in effect, we will pay to the beneficiary(ies) named in the application the temporary insurance Benefit ("TIA Benefit") described in the section below entitled "Benefit".

Questions

If any question listed below is answered "Yes" or left blank, NO COVERAGE will take effect under this Agreement.

The questions below apply to **all** Proposed Insured(s) shown on the application.

Question	YES	NO
1 Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, had surgery performed or recommended, or been advised to have a diagnostic test other than an HIV test?	☐	☐
2 Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider?	☐	☐
3 Has any person proposed for insurance ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or health care Provider?	☐	☐
4 Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐
5 Does amount applied for exceed $1,000,000?	☐	☐
6 Is the policy applied for a second to die life insurance policy?	☐	☐

No Coverage

There is NO temporary insurance coverage if:

1 No premium is submitted at the time this Agreement is submitted or if the premium check or electronic transaction is not honored;or
2 Any question listed above is answered "Yes" or left blank; or
3 There is a material misrepresentation in any answer to any question listed above or to any questions or statements in the application and/or any questionnaires and supplements to the application; or
4 Internal Revenue Code section 1035 exchange paperwork is received without full initial modal premium; or
5 A Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, in which case, United will not be liable under this Agreement except to return any payment paid with the application.

Benefit

For purposes of this Agreement, the TIA Benefit is an amount equal to the lesser of: (1) the amount of insurance applied for in the application; or (2) $1,000,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the TIA Benefit under this Agreement exceed $1,000,000.

Start Date

Any Temporary insurance coverage provided **STARTS** on the date all of the following requirements have been met:

1 This Agreement has been fully completed, signed and dated on the date of the application by the Proposed Insured(s), Applicant/Owner and Producer.
2 The full initial modal premium is received at our Home Office and made by check or authorized electronic transaction. A payment will be considered to be received only if one of the following valid items is received at our Home Office: (a) a check made payable to United of Omaha in the amount of the full first required premium; or (b) a completed and signed electronic transaction authorization for the first full premium.
3 All application information (including, but not limited to, all information necessary to complete the application and/or any questionnaires and supplements to the application) and any medical exam and tests required by United are completed. Notwithstanding the preceding sentence, if the Proposed Insured dies within 30 days after the date this Agreement is signed as a direct result of, independent from all other causes, accidental bodily injury that occurs after the date of this Agreement but before any medical exam and tests are completed, we will pay to the beneficiary(ies) named in the application the TIA Benefit.

End Date

This Agreement and any coverage provided hereunder will **END** on the earliest of the following dates:

1 90 days from the date of this Agreement; or
2 The date we deliver the policy applied for to the applicant/owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at a standard risk class; or (b) have declined to issue you a policy; or (c) will not provide temporary insurance coverage; or
4 The date the applicant/owner withdraws the application for insurance.

Signatures

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 United rejects or declines the application, United will refund the applicant any premium paid with the application.
I/We have read and received a copy of this Agreement and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledege and belief. I/We understand that the Producer has no authority to change the terms of this Agreement.

Signature of Proposed Insured ____________________ Date ____________________

Signature of Other Proposed Insured ____________________ Date ____________________

Signature of Applicant/Owner (if other than Proposed Insured) ____________________ Date ____________________

Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized $____________________

I/We have not received a check with the application if any question in the above section entitled "Questions" was answered "yes" or left blank. I/We agree that I/We am/are not authorized to change or waive the terms of this Agreement and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Agreement to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

Signature of Producer ____________________ Date ____________________

Signature of Producer ____________________ Date ____________________

T044LCA13A **PLEASE SUBMIT TO HOME OFFICE**

United of Omaha Life Insurance Company
A Mutual *of* Omaha Company

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS
The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance. If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death. Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser. Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

Disclosure for Term Life Insurance Policies

If you are applying for term life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

Benefit Description

For Term Life Complete

While this rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 92% of the policy's death benefit. [1] A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 24 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness.

For Term Life Answers

While this rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 94% of the policy's death benefit plus 94% of any rider's death benefit if that rider is on the Insured's life.

[2] If the sum of the policy's death benefit and the applicable riders' death benefit exceeds $500,000, the accelerated death benefit is not available. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date on the statement of proof of Terminal Illness.

[3] A physician must sign and date the statement of proof of Terminal Illness.

[1] *In* ***Indiana, Oregon****, and* ***Washington,*** 94%.

[2] *In* ***Washington,*** 88%.

[3] *In* ***Washington,*** 24 months.

Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

Disclosure for Universal Life Insurance Policies

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal and Chronic Illness Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

Benefit Description

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness or as being Chronically Ill, you may elect to receive an accelerated death benefit. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness. Chronically Ill means that the Insured is unable to perform at least two Activities of Daily Living and has been confined to a Nursing Home for 90 consecutive days or more. [4] A physician must certify that the Insured is Chronically Ill.

The amount available for an accelerated death benefit depends on your policy's current death benefit and the provisions of your policy. The aggregate total of all elections may not exceed $250,000. You may elect to receive the Chronic Illness benefit more than once. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the requested Chronic Illness benefit by an actuarial discount as determined by the factors described in the rider. For the Terminal Illness benefit, we will reduce the requested amount by 6%. We will also adjust the Terminal Illness benefit and each Chronic Illness benefit by a $100 charge and the pro-rated amount of any outstanding loans.

[4] *In* ***Virginia,*** *Nursing Home confinement requirement not applicable for Guaranteed Universal Life Complete.*

In ***Kansas****, Activities of Daily Living requirement not applicable for Guaranteed Universal Life Complete.*

In ***Oregon****, Nursing Home confinement must be expected to last for the duration of the Insured's life for AccumUL Plus.*

In ***Minnesota*** *and* ***North Carolina,*** *Nursing Home confinement must be expected to last for the duration of the Insured's life for Guaranteed Universal Life Complete.*

In ***Minnesota****, Chronically Ill may also mean the Insured requires substantial and protective supervision due to Severe Cognitive Impairment for Guaranteed Universal Life Complete.*

Effect of the Accelerated Death Benefit on the Policy

The rider will terminate when the Terminal Illness benefit is paid or the aggregate total of all elections reaches $250,000. If your policy includes a Return of Premium Benefit provision, we will reduce the premium used to calculate the Return of Premium benefit by the benefit paid. We will reduce the current amount of insurance coverage, tabular value, accumulation value, surrender value, and any policy loan by the same proportion as the requested reduction in the death benefit. We will base the future premium and policy charges on the reduced amount of insurance coverage.

Acknowledgment

I acknowledge receipt of this Disclosure Form

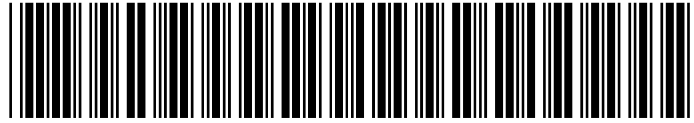
Applicant/Owner Signature _______________ Date _______________

I have provided this Disclosure Form to the Applicant

Producer Signature _______________ Date _______________

Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing

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



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.

The HIV Antibody Test — Description and Purpose of the Test

A series of tests will be performed by a licensed laboratory through a medically accepted procedure to determine whether you may have been infected with the HIV virus. This test is not a test for acquired immunodeficiency syndrome (AIDS). AIDS is a disease you get when HIV destroys your body's immune system, and can only be diagnosed by medical evaluation.

An initial ELISA blood test will be done. If the initial ELISA test is positive, then a repeat ELISA test will be performed. If the second ELISA test is positive, a Western Blot test will be conducted to confirm the positive ELISA test results.

Meaning of Test Results

Positive HIV antibody/antigen test results do not mean that 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/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Potential Uses and Disclosure of Test Results

Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application.

Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood, urine or oral specimen test may be reported to the Medical Information Bureau, a national insurance data bank, as a nonspecific abnormality determined by the testing of blood or oral specimen.

Limitations

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus.

Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when the infection occurred within the previous three to six months.

Counseling

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your own physician or your own health care provider. A list of counseling resources is provided for your information.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician ______________________________

Address ______________________________

Consent

I have read and I understand this Notice and Consent form. I voluntarily consent to testing 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.

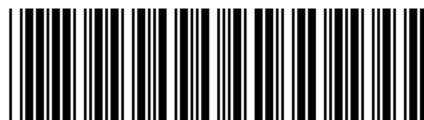
Date ____________________ ______________________________
Signature of Proposed Insured or Parent/Guardian

CLIENT FORMS

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s). **However, do not provide the TIA to the client if a check or electronic transaction for the initial premium was not collected at the time of application.**



Temporary Life Insurance Agreement (“Agreement”)

United of Omaha Life Insurance Company (“United”, “we”, “our”, “us”), Mutual of Omaha Plaza, Omaha, NE 68175

If any proposed insured dies while coverage under this agreement is in effect, we will pay to the beneficiary(ies) named in the application the temporary insurance Benefit (“TIA Benefit”) described in the section below entitled “Benefit”.

Questions

If any question listed below is answered “Yes” or left blank, NO COVERAGE will take effect under this Agreement.

The questions below apply to **all** Proposed Insured(s) shown on the application.

	Question	YES	NO
1	Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, had surgery performed or recommended, or been advised to have a diagnostic test other than an HIV test?	☐	☐
2	Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider?	☐	☐
3	Has any person proposed for insurance ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or health care Provider?	☐	☐
4	Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐
5	Does amount applied for exceed $1,000,000?	☐	☐
6	Is the policy applied for a second to die life insurance policy?	☐	☐

No Coverage

There is NO temporary insurance coverage if:

1 No premium is submitted at the time this Agreement is submitted or if the premium check or electronic transaction is not honored;or
2 Any question listed above is answered “Yes” or left blank; or
3 There is a material misrepresentation in any answer to any question listed above or to any questions or statements in the application and/or any questionnaires and supplements to the application; or
4 Internal Revenue Code section 1035 exchange paperwork is received without full initial modal premium; or
5 A Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, in which case, United will not be liable under this Agreement except to return any payment paid with the application.

Benefit

For purposes of this Agreement, the TIA Benefit is an amount equal to the lesser of: (1) the amount of insurance applied for in the application; or (2) $1,000,000 minus the amount of any insurance on the Proposed Insured’s life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the TIA Benefit under this Agreement exceed $1,000,000.

Start Date

Any Temporary insurance coverage provided **STARTS** on the date all of the following requirements have been met:

1 This Agreement has been fully completed, signed and dated on the date of the application by the Proposed Insured(s), Applicant/Owner and Producer.
2 The full initial modal premium is received at our Home Office and made by check or authorized electronic transaction. A payment will be considered to be received only if one of the following valid items is received at our Home Office: (a) a check made payable to United of Omaha in the amount of the full first required premium; or (b) a completed and signed electronic transaction authorization for the first full premium.
3 All application information (including, but not limited to, all information necessary to complete the application and/or any questionnaires and supplements to the application) and any medical exam and tests required by United are completed. Notwithstanding the preceding sentence, if the Proposed Insured dies within 30 days after the date this Agreement is signed as a direct result of, independent from all other causes, accidental bodily injury that occurs after the date of this Agreement but before any medical exam and tests are completed, we will pay to the beneficiary(ies) named in the application the TIA Benefit.

End Date

This Agreement and any coverage provided hereunder will **END** on the earliest of the following dates:

1 90 days from the date of this Agreement; or
2 The date we deliver the policy applied for to the applicant/owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at a standard risk class; or (b) have declined to issue you a policy; or (c) will not provide temporary insurance coverage; or
4 The date the applicant/owner withdraws the application for insurance.

Signatures

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 United rejects or declines the application, United will refund the applicant any premium paid with the application.

I/We have read and received a copy of this Agreement and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledege and belief. I/We understand that the Producer has no authority to change the terms of this Agreement.

Signature of Proposed Insured ____________________ Date ____________________

Signature of Other Proposed Insured ____________________ Date ____________________

Signature of Applicant/Owner (if other than Proposed Insured) ____________________ Date ____________________

Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized $__________________

I/We have not received a check with the application if any question in the above section entitled “Questions” was answered “yes” or left blank. I/We agree that I/We am/are not authorized to change or waive the terms of this Agreement and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Agreement to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

Signature of Producer ____________________ Date ____________________

Signature of Producer ____________________ Date ____________________

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance. If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death. Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax adviser. Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

Disclosure for Term Life Insurance Policies

If you are applying for term life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

Benefit Description

For Term Life Complete

While this rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 92% of the policy's death benefit. [1] A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 24 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness.

For Term Life Answers

While this rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 94% of the policy's death benefit plus 94% of any rider's death benefit if that rider is on the Insured's life.

[2] If the sum of the policy's death benefit and the applicable riders' death benefit exceeds $500,000, the accelerated death benefit is not available. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date on the statement of proof of Terminal Illness.

[3] A physician must sign and date the statement of proof of Terminal Illness.

[1] *In **Indiana**, **Oregon**, and **Washington**,* 94%.

[2] *In **Washington**,* 88%.

[3] *In **Washington**,* 24 months.

Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

Disclosure for Universal Life Insurance Policies

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal and Chronic Illness Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

Benefit Description

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness or as being Chronically Ill, you may elect to receive an accelerated death benefit. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness. Chronically Ill means that the Insured is unable to perform at least two Activities of Daily Living and has been confined to a Nursing Home for 90 consecutive days or more. [4] A physician must certify that the Insured is Chronically Ill.

The amount available for an accelerated death benefit depends on your policy's current death benefit and the provisions of your policy. The aggregate total of all elections may not exceed $250,000. You may elect to receive the Chronic Illness benefit more than once. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the requested Chronic Illness benefit by an actuarial discount as determined by the factors described in the rider. For the Terminal Illness benefit, we will reduce the requested amount by 6%. We will also adjust the Terminal Illness benefit and each Chronic Illness benefit by a $100 charge and the pro-rated amount of any outstanding loans.

[4] *In **Virginia**, Nursing Home confinement requirement not applicable for Guaranteed Universal Life Complete.*

*In **Kansas**, Activities of Daily Living requirement not applicable for Guaranteed Universal Life Complete.*

*In **Oregon**, Nursing Home confinement must be expected to last for the duration of the Insured's life for AccumUL Plus.*

*In **Minnesota** and **North Carolina**, Nursing Home confinement must be expected to last for the duration of the Insured's life for Guaranteed Universal Life Complete.*

*In **Minnesota**, Chronically Ill may also mean the Insured requires substantial and protective supervision due to Severe Cognitive Impairment for Guaranteed Universal Life Complete.*

Effect of the Accelerated Death Benefit on the Policy

The rider will terminate when the Terminal Illness benefit is paid or the aggregate total of all elections reaches $250,000. If your policy includes a Return of Premium Benefit provision, we will reduce the premium used to calculate the Return of Premium benefit by the benefit paid. We will reduce the current amount of insurance coverage, tabular value, accumulation value, surrender value, and any policy loan by the same proportion as the requested reduction in the death benefit. We will base the future premium and policy charges on the reduced amount of insurance coverage.

Acknowledgment

I acknowledge receipt of this Disclosure Form

Applicant/Owner Signature ______________________ Date ____________

I have provided this Disclosure Form to the Applicant

Producer Signature ______________________ Date ____________

FULLY UNDERWRITTEN – GIVE THIS COPY TO THE APPLICANT

The HIV Virus

Many people who are infected with the HIV virus have not developed any symptoms, while others have had relatively minor illnesses. The most serious form of illness caused by the virus is Acquired Immune Deficiency Syndrome (AIDS), which involves loss of the body's natural immune defenses against disease.

AIDS is a life-threatening disorder of the immune system. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and persons who have had sexual contact of any of these persons.

The only reliable way to tell if you are infected with HIV is to get tested. This is because many people with HIV do not experience symptoms for years after the initial infection or have symptoms that are very similar to symptoms of other illnesses. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

The AIDS Antibody Test

HIV antibody tests are the most appropriate test for routine diagnosis of HIV among adults. Antibody tests are inexpensive and very accurate. The ELISA antibody test (enzyme-linked immunoabsorbent) also known as EIA (enzyme immunoassay) was the first HIV test to be widely used.

Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your own physician or your own health care provider.

Counseling Resources List

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to the Insurer. Therefore, the Insurer makes no representations or warranties that this information is accurate as of the date you receive this list. Also, the Insurer makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE – U.S. PUBLIC HEALTH SERVICE
1-800-342-AIDS

SPANISH AIDS HOTLINE
1-800-222-SIDA

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM – BAKERSFIELD
(805) 861-3631

CENTRAL VALLEY AIDS TEAM
Fresno
(209) 264-2436

AIDS PROJECT – EAST BAY
Oakland
(415) 420-8181

SACRAMENTO AIDS FOUNDATION
Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION
San Francisco
(415) 864-5855

SANTA CLARA COUNTY ARIS PROJECT
CAMPBELL
(408) 370-3272

SONOMA COUNTY AIDS FOUNDATION HOTLINE
(707) 579-AIDS

AIDS HOTLINE
So. California
1-800-922-AIDS

HEMOPHILIA FOUNDATION OF SO. CA
Social Services – So. California
Hemophilia AIDS Information
(818) 793-6192 (714) 740-2222

CALIFORNIA DEPARTMENT OF HEALTH SERVICES – Statewide Services
Office of AIDS – Sacramento
(916) 323-7415

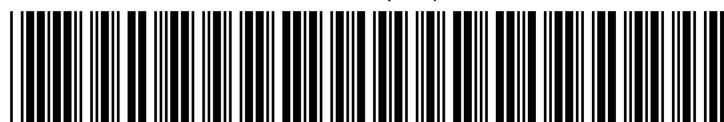
AIDS SERVICES FOUNDATION OF ORANGE COUNTY
Costa Mesa
(714) 646-0411

AIDS PROJECT – LOS ANGELES
West Hollywood
(213) 876-8951

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(714) 784-2437

SANTA BARBARA COUNTY AIDS INFORMATION HOTLINE
(805) 965-2925

SHASTA COUNTY HELPLINE
(916) 225-5252



GIVE THIS COPY TO THE APPLICANT

United of Omaha Life Insurance Company – MIB, 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 Inc., 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 Inc. Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB Inc. will arrange disclosure of any information it may have in your file. Please contact MIB Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB Inc.'s file, you may contact MIB Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB Inc.'s information is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734

United of Omaha Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB Inc. may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Disclosure Statement

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

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

Upon written request we will inform you whether an investigative consumer report was requested, 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.

If you request any additional disclosures from either Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company, please send your request to the following address: Attention: Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, NE 68175. Following this Notice is a written Summary of Your Rights under Section 609(c) of the Fair CreditReporting Act, as amended.

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. Upon request, 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.

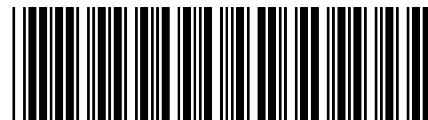
Sale or Liquidation of Assets Disclosure to Elders

California Insurance Code ß789.8 requires that the following notice be given to all prospective purchasers of life insurance or annuities, age 65 or over:

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

GIVE THIS COPY TO THE APPLICANT



Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

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.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, D.C. 20552.**

- **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.consumerfinance.gov/learnmore 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.consumerfinance.gov/learnmore 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.consumerfinance.gov/learnmore.
- **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 1-888-567-8688.
- **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.consumerfinance.gov/learnmore.

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. For information about your federal rights contact:

TYPE OF BUSINESS:	CONTACT:
1. a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates **b.** Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB	**a.** Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552 **b.** Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: **a.** National banks, federal savings associations and federal branches and federal agencies of foreign bank **b.** State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act **c.** Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations **d.** Federal Credit Unions	**a.** Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 **b.** Federal Reserve Consumer Help Center PO Box 1200 Minneapolis, MN 55480 **c.** FDIC Consumer Response Center 1100 Walnut St., Box #11 Kansas City, MO 64106 **d.** National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area Supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357

GIVE THIS COPY TO THE APPLICANT

United of Omaha Life Insurance Company
A Mutual *of* Omaha Company

Notice Regarding Replacement
Replacing Your Life Insurance Policy or Annuity?

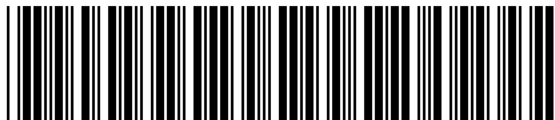
Are you thinking about buying a new life insurance policy or an annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in **your** best interest.

We are required by law to notify your existing company that you may be replacing their policy.

____________________	________	____________________
Applicant’s/Owner's Signature	Date	Agent’s Signature



Company’s Copy

Notice Regarding Replacement
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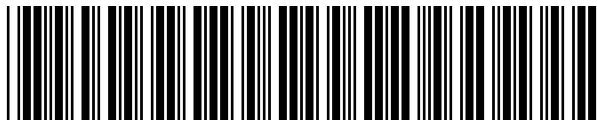
Applicant's/Owner's Signature	Date	Agent's Signature



Applicant's/Owner's Copy

Fit Test

Name: ______________________________

Date: ______________________________

Complete with ALL Fully Underwritten Term and UL Applications

Requirements

- Ages 18-75
- Minimum face amount: $100,000
- Maximum face amount: $5,000,000 ($10,000,000 for GULS) Total coverage in force and applied for with United of Omaha and Companion Life Insurance companies
- Nontobacco users
- Base rating *after* normal credits of table 4 or less
- Does not apply to "flat extra" ratings or those with CAD prior to age 50 or Type I Diabetes, or ratable substance abuse, stroke or cancer histories

If your client has several of the following characteristics they may qualify for up to an *additional two table credits* from the base rating on both fully underwritten term and permanent insurance.

Note: No more than two lifestyle characteristics can be applied toward credits

3 Characteristics = 1 table credit   5 Characteristics = 2 table credits

Lifestyle Characteristics

Check all that apply

Regular preventative medical care and compliant follow-up for treated impairments within past 12 months? .... ☐ **Yes**
No tobacco use for past 10 years? .... ☐ **Yes**
Income › $100,000 or net worth › $1,000,000? .... ☐ **Yes**
Preferred or better driving record? .... ☐ **Yes**

Medical Characteristics

Great family history – no deaths from any disease prior to age 70? .... ☐ **Yes**
Cholesterol/HDL ratio under 5.0? .... ☐ **Yes**
A1c test ‹ 5.7? .... ☐ **Yes**
Serum albumin › 4.2 ages 61-75? .... ☐ **Yes**
Negative cardiac testing: GXT, non-imaged or imaged (stress echo, perfusion study), echocardiogram, EBCT or angiography (within the past 2 years)? .... ☐ **Yes**
GXT exercise performance over 10 METS (within the past 2 years)? .... ☐ **Yes**
Optimal blood pressure control-treated or untreated with average of 135/85 or better? .... ☐ **Yes**
Preferred or better build, ages 18-60. Standard plus or better build, ages 61-75? .... ☐ **Yes**
BNP ‹100 ages 61-75? .... ☐ **Yes**
Normal CBC ages 61-75? .... ☐ **Yes**

If you answered yes to 3 or more of these questions, you may qualify for additional table credits.

Submit with Application

L8191_0414

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

Acknowledgment/Illustration Certification Form - Universal Life Policies

Note: If an illustration matching the policy applied for was signed at the point of sale, do not use this form. Submit the signed illustration.

PRODUCER/AGENT

I, the Producer/Agent, hereby certify that (check only one):

- ☐ No illustration was used in the sale of the life insurance policy applied for.
- ☐ The life insurance policy applied for is other than as shown in the policy illustration.
- ☐ I certify that I displayed a computer screen illustration for ______________________ that complies with state requirements and for which no hard copy was furnished. The illustration was based on the personal and policy information below.

______________________ Print Name of Proposed Insured	______________________ Print Name of Other Proposed Insured
Age: __________	Age: __________
Gender: ☐ Male ☐ Female	Gender: ☐ Male ☐ Female
Underwriting or Rating Class: ______________	Underwriting or Rating Class: ______________

Type of Policy: ______________________ Initial Death Benefit $: ______________________

SIGNATURES

I make the certifications stated above:

______________________ ______________
Signature of Producer/Agent Date

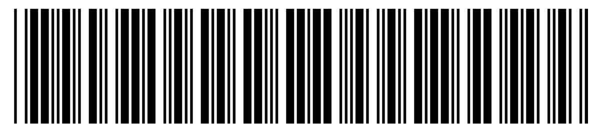
As an Applicant/Owner, I certify that the Producer/Agent statements made above are true. I understand that an illustration conforming to the policy as issued will be provided to me no later than the time the policy is delivered.

______________________ ______________
Print Name of Applicant/Owner Date

______________________ ______________
Signature of Applicant/Owner Date

PLEASE SUBMIT

United of Omaha Life Insurance Company
A Mutual *of* Omaha Company



Notice Regarding Standards for Medi-Cal Eligibility and Recovery

For Distribution by Insurers, Agents, and Brokers

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message! You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

Recovery

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than $2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $115,920 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income, or $2,898 in monthly income, whichever is greater.

Fair Hearing and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $115,920 in countable resources. The order also may allow the at-home spouse to retain more than $2,898 in monthly income.

Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

- **One Principal Residence.** One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday. The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

  Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- **Real Property Used In A Business Or Trade.** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

- **IRAs, Keoghs, and Other Work-Related Pension Plans.** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- **Personal Property Used In A Trade or Business.**
- **One Motor Vehicle.**
- **Irrevocable Burial Trusts or Irrevocable Prepaid Burial Contracts.**

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

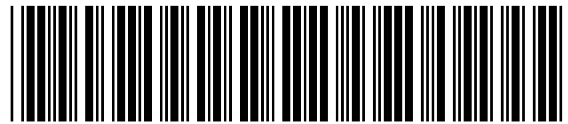
I have read the above notice and have received a copy.

____________________ ____________________ ____________________

(Applicant's/Owner's Signature) (Date) (Spouse's Signature) (Date) (Legal Representative's Signature) (Date)

Note: For Married couples, the resource limit and income limit generally increase a slight amount on January 1 of every year.

United of Omaha Life Insurance Company
A Mutual *of* Omaha Company



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If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message! You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

Recovery

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than $2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $115,920 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income, or $2,898 in monthly income, whichever is greater.

Fair Hearing and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $115,920 in countable resources. The order also may allow the at-home spouse to retain more than $2,898 in monthly income.

Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

- **One Principal Residence.** One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday. The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

  Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.
- **Real Property Used In A Business Or Trade.** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

- **IRAs, Keoghs, and Other Work-Related Pension Plans.** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- **Personal Property Used In A Trade or Business.**
- **One Motor Vehicle.**
- **Irrevocable Burial Trusts or Irrevocable Prepaid Burial Contracts.**

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

I have read the above notice and have received a copy.

(Applicant's/Owner's Signature)	(Date)	(Spouse's Signature)	(Date)	(Legal Representative's Signature)	(Date)

Note: For Married couples, the resource limit and income limit generally increase a slight amount on January 1 of every year.

Trust Certification

Use this form in situations where a trust will be the owner of a life insurance policy or annuity policy to be issued by United of Omaha Life Insurance Company ("United of Omaha"). The Trustee(s) is/are to complete and execute this form. United of Omaha reserves the right, at all times, to request a copy of the executed trust document.

General Information

Name of Trust: ______________________________

Name(s) of Trustee(s): ______________________________

Successor Trustee(s) if any: ______________________________

Date Trust was executed: ______/______/______ State where executed: ______________________

Trust Beneficiaries	Relationship to Insured
______________________	______________________
______________________	______________________
______________________	______________________

Grantor(s) of the Trust

Name(s) of Grantor(s) who established the Trust: ______________________________

Authorized Individuals

The Trust authorizes you to accept instructions from: (please check one)

☐ Any one Trustee independently ☐ Multiple Trustees all must authorize ☐ Other(please specify)________________

____

The Trustee(s) named in the above section, does/do hereby certify the following:

1. The Trust is: ☐ Irrevocable and is in full force and in effect ☐ Revocable and is in full force and in effect
2. The named Trust will be the owner of the insurance policy(ies) or annuity(ies) applied for with/used by United of Omaha.
3. I/We are qualified to act under the terms of the Trust provisions and/or applicable law. I/We have the power to exercise all rights associated with ownership of the insurance policy(ies) or annuity(ies), including but not limited to the purchase, surrender, withdrawal of available cash value, taking a loan, assigning the policy(ies) or annuity(ies) and making payment of proceeds to designated beneficiaries.
4. Unless United of Omaha is notified otherwise, at any time there is more than one Trustee listed above, the Trust authorizes United of Omaha to comply with the requests of any one Trustee regarding this policy(ies) or annuity(ies).
5. I/We agree jointly and individually to indemnify United of Omaha and its agents, and to hold it/them harmless from and against any and all liability as a result of claims, demands, damages, or judgments arising out of its/their reliance on this Trust Certification.
6. I/We agree to inform United of Omaha in writing of any Trust amendments, change of Trustee(s), or other facts and events that would materially affect or alter this Trust Certification or the information contained herein.
7. I/We understand and agree that United of Omaha has no knowledge of and makes no representations as to the validity or sufficiency of the Trust which owns the insurance policy(ies) or annuity(ies), or the legal or tax ramifications of the Trust ownership.
8. The Proposed Insured(s) has/have been informed that a life insurance policy(ies) or annuity(ies) is being purchased on his/her/their life/lives.

Certification

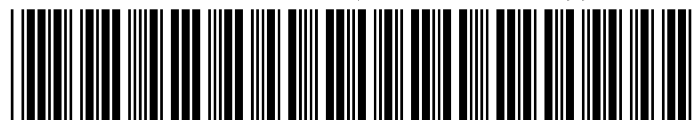
By signing below, I/We certify that I/We are the Trustee(s) of the above named Trust and that I/We are applying for a life insurance policy or annuity policy insuring the life/lives of the Proposed Insured(s) appearing below.

Signed at ______________________ this _______ day of __________________ ___________.
City/State Month Year

____
Signature of Trustee(s)

Proposed Insured(s)

By signing below, I/We certify that I/We understand that a policy(ies) of life insurance or an annuity has/have been applied for on my/our life/lives to be owned by the Trust named above.



____
Signature(s) of the Proposed Insured(s)

AFN33502_0605

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

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. The 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. The consent should include, but 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 employer 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 Employee ______________________________

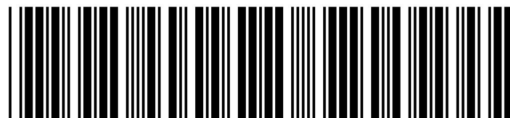
Print Name ______________________________

Position or Title ______________________________ Date ______________

Employee 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



AFN40375

The Bank Service Plan

"Just One Less Thing You Have To Worry About."

By applying for the BANK SERVICE PLAN, you can save time in paying bills and money for postage. Most importantly, your coverage won't lapse because a payment was overlooked.

With the BANK SERVICE PLAN, you enjoy the privacy and convenience of having your premiums deducted automatically each month from your checking account. And you have the assurance of knowing that your premiums will be paid on time.

The BANK SERVICE PLAN offers you...

Automatic Payments — You tell us when to deduct your premium from your checking account each month.

No Postage To Pay — Because you won't have to send us a check every month, you save on postage rates.

A Secure Way To Pay — No more worries about your coverage lapsing because your check got lost or delayed in the mail.

It's all handled for you automatically.

How to Sign Up

1. Complete both forms below, making sure to write your name as shown on your checking account. Be sure to keep your copy of the Authorization Form in a secure place.
2. Send your check for the amount indicated in the enclosed letter. We'll use the account number on your check to put your BANK SERVICE PLAN (BSP) payments into effect. So it's important your check is from the account you want your payments withdrawn.
3. Return your completed Authorization Form with your check in the envelope provided.

Each month, a preauthorized withdrawal is prepared for the exact amount of the premium and is sent to your financial institution. The amount of the preauthorized withdrawal is deducted from your account balance and will appear on your monthly statement.

The preauthorized withdrawal will be sent to your financial institution on the specified day, and your premium is paid until the next month when the process is repeated.

It's that simple — so sign up today and begin making your insurance payments the modern, convenient way.

Authorization for Your Records – Please Sign and Date

I authorize Mutual of Omaha Insurance Company and/or its insurance affiliates* ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

*United of Omaha Life Insurance Company • United World Life Insurance Company • Omaha Insurance Company

X ______________________ X ____

Date Authorized Signature on Account

For more information on this type of payment method, or any of the other outstanding services provided, just call **(800) 775-6000** or write to us at: Mutual of Omaha Plaza, Omaha, Nebraska 68175-0001

(CUSTOMER COPY – RETAIN FOR YOUR RECORDS)

Ongoing Premium Payments

☐ **Automated Bank Account Withdrawal (Monthly)**

Health: Specify the date premiums will be withdrawn: ☐ 1st of the Month or ☐ 15th of the Month

Life: Specify the date premiums will be withdrawn: _______ 1st through the 28th

Ongoing premiums are due and will be automatically withdrawn from the account below on the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

Policy(s) Information

List the policies/certificates/I.D. number/contract to be paid by your checking account:

(1) ______________ I.D. Number ______________________ Customer

(2) ______________ I.D. Number ______________________ Customer

(3) ______________ I.D. Number ______________________ Customer

(4) ______________ I.D. Number ______________________ Customer

(5) ______________ I.D. Number ______________________ Customer

(6) ______________ I.D. Number ______________________ Customer

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

______________________________ Insured under Existing BSP

______________________________ Existing BSP Contract Number

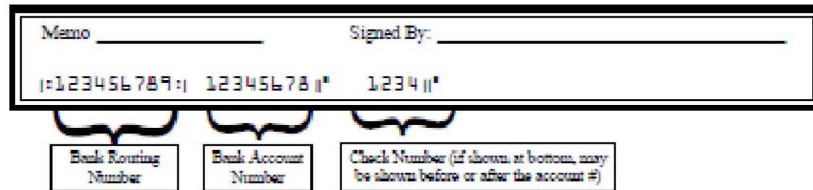
Account Information

Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution: ____

Complete information below or attach a voided check here.

Bank Routing Number: ______________________ Bank Account Number: ______________________
(Do not use Debit/Credit Card numbers)



Authorization

I authorize Mutual of Omaha Insurance Company and its insurance affiliates* ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

*United of Omaha Life Insurance Company • United World Life Insurance Company • Omaha Insurance Company

X ______________________ Date

X ______________________________________ Authorized Signature on Account

Return This Form With Your Voided Check

M20777_0812

(HOME OFFICE COPY)