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

APPLICATION FOR WHOLE LIFE EXPRESS

CALIFORNIA

LAP1147_CA_0513

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

✍ *CHECKLIST FOR SUBMITTING A COMPLETED APPLICATION*

Please mail application and appropriate forms to:
United of Omaha Life Insurance Company, Attn: Individual Life Underwriting, 9330 State Hwy 133, Blair, NE 68008

☐ **Application**
1 Answer all questions completely and legibly.
2 If citizenship question is answered "No," complete Foreign National and Foreign Travel Questionnaire.
3 Be sure the application is signed and dated in all places indicated by the Proposed Insured and the applicant if other than the Proposed Insured.
4 Any changes should be initialed by the Proposed Insured and, if applicable, the Applicant.
5 Use age last birthday.

☐ **Have Client sign 'Authorization to Disclose Personal Information' (Combo HIPAA/MIB Authorization) and submit with application**.

☐ **Complete Premium Collection Section**
A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected.

☐ **Have Client sign 'Conditional Receipt'**
Submit the Conditional Receipt with the application.

☐ **Attach copy of the proposal illustration (if available)**

☐ **Leave all applicable forms and Life Buyer's Guide with the Proposed Insured.**

☐ **Financial Institution Consumer Disclosure**
If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

☐ **Any Additional Information or Comments**
Include any supplemental information about your client

_____

_____

_____

_____

_____

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION

L8557

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Section A PROPOSED INSURED INFORMATION

Name (First, Middle Initial, Last)

Mailing Address | City | State | ZIP Code

Social Security Number	Sex	Date of Birth	Age	Telephone Number
– –	☐ Male ☐ Female	/ /		( ) –

Secondary Addressee Information. Please provide name, address and phone number (A copy of any notification of possible policy lapse will be sent to this person) (Optional)

Are you a citizen of the United States? ☐ **Yes** ☐ **No**

(If "No," complete Foreign National and Foreign Travel Questionnaire and list details below.)

Documentation (select one): ☐ Permanent Resident Card (Card number _____)

☐ Visa (specify type _____)

Date of Arrival in the United States: _____ /_____

Owner/Applicant Information (Complete only if Owner/Applicant is different from Proposed Insured)

Owner's Name (First, Middle Initial, Last)

Owner's Mailing Address | City | State | ZIP Code

Social Security Number	Sex	Date of Birth	Age	Telephone Number
– –	☐ Male ☐ Female	/ /		( ) –

Relationship to Proposed Insured

Are you a citizen of the United States? ☐ **Yes** ☐ **No**

(If "No," complete Foreign National and Foreign Travel Questionnaire and list details below.)

Documentation (select one): ☐ Permanent Resident Card (Card number _____)

☐ Visa (specify type _____)

Date of Arrival in the United States: _____ /_____

Section B UNDERWRITING INFORMATION (Complete if applying for Whole Life Express)

Height _____ Weight _____ Birth State _____

Driver's License Number/State of Issue _____

In the past 12 months, has the proposed insured used any form of tobacco or nicotine replacement therapy? ☐ **Yes** ☐ **No**

IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN SECTION B, THAT PERSON IS NOT ELIGIBLE FOR WHOLE LIFE EXPRESS COVERAGE.

	Yes	**No**
1. Has the Proposed Insured **ever** been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or health care provider?	☐	☐
2. Is the Proposed Insured **currently**:		
(a) bedridden or confined to any hospital, nursing home, or other medical facility?	☐	☐
(b) using any of the following: wheelchair, electric scooter, oxygen or catheter?	☐	☐
3. **In the past 6 months,** has the Proposed Insured:		
(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?	☐	☐
(b) received, or been advised to have, any of the following: care in a nursing home, assisted living facility, adult day care facility; or home health care services?	☐	☐

Section B UNDERWRITING INFORMATION – continued

		Yes	No
4.	Has the Proposed Insured **ever** (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for, or (c) consulted with a health care provider regarding:		
(a)	Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease or Replacement, Cardiomyopathy, Congenital Heart Disease, Stroke, or Cerebral or Symptomatic Aneurysm?	☐	☐
(b)	Chronic Lung Disease (except mild Asthma), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis?.....	☐	☐
(c)	Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Demyelinating Disease including Multiple Sclerosis; Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down's Syndrome or any other disease of the central nervous system?	☐	☐
(d)	Chronic Kidney Disease, end-stage Renal Disease with dialysis or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C?	☐	☐
(e)	Diabetes with onset before age 50 or with vascular or renal complications?.....	☐	☐
(f)	an organ transplant?	☐	☐
(g)	Systemic lupus or Scleroderma?.....	☐	☐
5.	**In the past 10 years,** has the Proposed Insured:		
(a)	been treated or advised to be treated for alcoholism, alcohol use, or any drug/substance use?	☐	☐
(b)	been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had 4 or more moving violations?	☐	☐
(c)	been convicted of a felony?	☐	☐
(d)	been hospitalized for high blood pressure or any mental or nervous disorder?.....	☐	☐
(e)	been treated or advised to be treated for Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell skin cancer)?	☐	☐
6.	**In the next 2 years,** will the Proposed Insured engage in any motor sports racing or activities, boat racing, parachuting, hang gliding, rock or mountain climbing, or skydiving?.....	☐	☐
7.	**In the past 12 months,** has the Proposed Insured been advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes, treatment, or other procedure which has not been done?.....	☐	☐
8.	**In the past 12 months,** has the Proposed Insured consulted a physician for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding?.....	☐	☐

Section C PLAN AND BENEFICIARY INFORMATION

Plan Information

☐ Whole Life Express

Face Amount $_____ Modal Premium $_____ Amount Collected $_____

Beneficiary Information

Primary Beneficiary Name	Contingent Beneficiary Name
Relationship	Relationship
Social Security Number – –	Social Security Number – –

Section D OTHER COVERAGE AND REPLACEMENT INFORMATION

1. List below all life insurance policies and/or annuity contracts on the Proposed Insured that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) If none, check the following box:..... ☐ None

2. Have you had, or do you intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? ..... ☐ Yes ☐ No

If "Yes," complete the appropriate box(es) below.
The Producer shall comply with any additional state and/or company replacement requirements.

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

Section E BILLING INFORMATION

Method of Payment: ☐ Annual ☐ Semiannual ☐ Quarterly
☐ Monthly Bank Service Plan (select one below)

AUTHORIZATION TO WITHDRAW FUNDS BY UNITED OF OMAHA LIFE INSURANCE COMPANY (United of Omaha)

(If Mode of Payment is Monthly Bank Service Plan (BSP) – select one below)

☐ Monthly Bank Service Plan **(initial premium collected with the application)** — I/We have paid the initial premium by check to United of Omaha.

☐ Monthly Bank Service Plan **(initial premium paid by electronic funds transfer)**— I/We authorize the initial premium for the policy(ies) to be paid to United of Omaha, by electronic funds transfer, from the bank account identified below. The withdrawal for the initial premium payment will occur only if and when the application(s) is/are approved for issue by United of Omaha.

By signing below, I/We authorize renewal premiums to be automatically paid to United of Omaha, by electronic fund transfer, from the bank account identified below and on the date specified below. I/We understand and agree that these authorized withdrawals from the bank account for premium payments will continue until this authorization is cancelled in writing.

If Monthly Bank Service Plan, complete information below **OR** attach a voided check:

Routing Number and Transit Number (9-digit number) _____

Account Number _____

Name as shown on account _____
First Initial Last

_____
Authorized Signature as shown on account

Social Security Number of Payor _____ – _____ – _____

Specify the date renewal premiums will be withdrawn (1st through the 28th of each month) _____

Section F PLEASE READ AND SIGN

If applying for Whole Life Express:

AUTHORIZATION TO RECEIVE INFORMATION FROM AND DISCLOSE INFORMATION TO MIB, INC.

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

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

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

I also authorize United of Omaha Life Insurance Company and its reinsurers to disclose Personal Information about me to MIB, Inc. I understand that the 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 submit a claim for benefits.

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

Continued on next page

Section F PLEASE READ AND SIGN – continued

Agreement:

I, the Undersigned, and the undersigned Producer(s), certify that we have read the completed application, or have had it read to us, and agree to the following:

1. All answers in this application (a) are true and complete; (b) will be relied on to determine insurability; and (c) which are incorrect or misleading, may void this application and any issued policy effective the issue date.
2. Except for coverage provided under the terms of a Conditional Receipt, if issued, the life insurance policy applied for will not take effect until it is issued by us and all of the following requirements are met: (a) the policy is delivered to and accepted by the policyowner; (b) the first full premium has been paid according to the mode of payment specified in the application; (c) the Proposed Insured is still alive; and (d) there has been no change in the Proposed Insured's health or habits, or the answers to any of the questions in the application, from the date the application is approved by United of Omaha's Underwriting Department to the date the policy is delivered and accepted by the policyowner.
3. In no event will benefits be paid for the same loss under both a Conditional Receipt and any policy issued from this application.
4. If the Applicant is other than the Proposed Insured, the Applicant will own the policy.
5. No Producer can: (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
6. REQUESTED POLICY ISSUE DATE (if applicable). _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

If applying for Whole Life Express: I have received the MIB, Inc. Pre-Notice, the Notice of Information Practices, and a Life Insurance Buyer's Guide before completing this application.

I approve the answers to the questions in this application as recorded.

I have read and understand the Authorization to Receive Information From and Disclose Information to MIB, Inc. and the Agreement Section.

Signed at: _____ Date: _____
City State

_____
Signature of Proposed Insured (Age 15 and Older)

_____ _____
Signature of Parent or Guardian (if Proposed Insured under age 15) Signature of Applicant/Owner/Trustee (If other than Proposed Insured)

Producer Statement:

In addition to the above, by signing below, I/we, the Producer(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

Do you, the Producer(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy and/or annuity contract? ..... ☐ **Yes** ☐ **No**

Has the Proposed Insured informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? ..... ☐ **Yes** ☐ **No**

(If either question is answered "Yes," fulfill all state and company requirements.)

_____ _____ _____
Signature of Producer #1 Production Number Date

_____ _____ _____
Signature of Producer #2 Production Number Date

_____ _____ _____
Print or Stamp Producer #1 Name Print or Stamp Producer #2 Name Agency Name

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

Conditional Receipt ("Receipt")

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

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

Date of Receipt:_____

Benefit

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2)$50,000 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 Conditional Receipt benefit under this Receipt exceed $50,000.

Conditions

Conditions under which a benefit may be payable under this Receipt prior to policy delivery:

1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and
2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and
3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and
4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.

If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.

End Date

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

1 60 days from the date of this Receipt; 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 the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 the date the Applicant/Owner withdraws the application for insurance.

Signatures

This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt 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 Receipt 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 knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

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

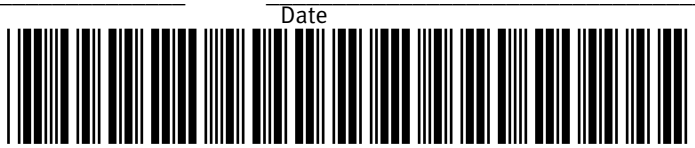
Payment Method: Check ☐ Electronic Transaction Authorization ☐ No Money Collected ☐

If by check, amount remitted $_____

I have not accepted a money order with this Receipt. I agree that I am not authorized to change or waive the terms of this Receipt and represent that I have not attempted to do so. I/We have read and explained the terms of this Receipt 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



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).

Conditional Receipt ("Receipt")

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

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

Date of Receipt:_____

Benefit

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2)$40,000 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 Conditional Receipt benefit under this Receipt exceed $40,000.

Conditions

Conditions under which a benefit may be payable under this Receipt prior to policy delivery:

1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and
2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and
3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and
4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.

If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.

End Date

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

1 60 days from the date of this Receipt; 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 the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 the date the Applicant/Owner withdraws the application for insurance.

Signatures

This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt 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 Receipt 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 knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

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

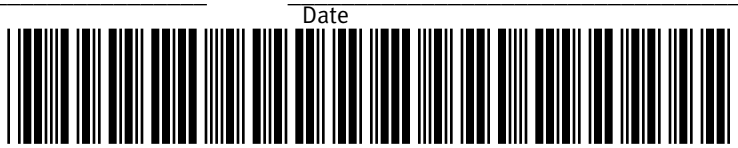
Payment Method: Check ☐ Electronic Transaction Authorization ☐ No Money Collected ☐

If by check, amount remitted $_____

I have not accepted a money order with this Receipt. I agree that I am not authorized to change or waive the terms of this Receipt and represent that I have not attempted to do so. I/We have read and explained the terms of this Receipt 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 – 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, where applicable. You also have the right to seek correction of personal information you believe to be inaccurate. In the event of an adverse underwriting decision, our Company will provide in writing the specific reason for the underwriting decision.

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.

L8303

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.

L7941

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.

L8420_CA

GIVE THESE NOTICES TO THE APPLICANT

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

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

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

Life Application Submission Form

Send to: Individual Life Underwriting
United of Omaha Life Insurance Company
9330 State Hwy 133
Blair, NE 68008

Comments: _____

_____

_____

Name of Insured

Name of Agent	Production Number	Phone Number	Email Address

Next Highest Upline	Production Number	Phone Number	Email Address

Please list any underwriting requirements that have already been ordered by the agent or Master General Agent/Broker General Agent.

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

Notice Regarding Standards for Medi-Cal Eligibility and Recovery

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 does not have more than $2,000 in countable assets.

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.

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.

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

Dated: _____ Signature: _____
(Applicant's/Owner's signature)

Signature: _____
(Spouse and legal representative)

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

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CALIFORNIA SENIOR NOTIFICATION

NOTE TO AGENT:
A person who meets with a senior in the senior's home is required to deliver a notice in writing to the senior no less than 24 hours and no more than 14 days prior to that individual's initial meeting in the senior's home. If the senior has an existing insurance relationship with an agent and requests a meeting with the agent in the senior's home the same day, a notice shall be delivered to the senior prior to the meeting.

Proposed Insured Name: _____

1. The agent's full name as it appears on his or her California insurance license:

_____

2. Agent's license number:_____

3. The agent's mailing address and telephone number listed on his or her California insurance license:_____

4. Disclosures:

A. I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following:

☐ **Life insurance, including annuities.**

☐ **Other insurance products (specify):**_____.

B. You have the right to have other persons present at the meeting, including family members, financial advisors, or attorneys.

C. You have the right to end the meeting at any time.

D. You have the right to contact the Department of Insurance for information, or to file a complaint. You may reach the Department of Insurance at:

California Department of Insurance
Consumer Communications Bureau
1-800-927-4357 (within CA) or 1-213-897-8921 (outside CA)

E. The following individuals will be coming to your home:

_____
Name **License Number (if applicable)**

_____
Name **License Number (if applicable)**