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

California– Application for Life Insurance

Living Promise Product – 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
FAX: 1-402-997-1800

☞ Please choose the precise Plan, Rider, and amount of insurance applied for

❑ **Level Benefit Product:**	❑ **Graded Benefit Product (if available):**
• Accelerated Death Benefit Rider • Accidental Death Benefit Rider (optional)	• No Riders Available

Application Submission Guidelines

- ❑ Attach a cover letter or additional information as needed.
- ❑ Always submit the Producer Report page.
- ❑ Leave all applicable forms and Life Buyer's Guide with the Proposed Insured.
- ❑ 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.

Important Forms

- ❑ Replacement Notice – if applicable, the client must sign and retain a copy for their records
- ❑ Payment Authorization – Complete this form if applicable
- ❑ Conditional Receipt – Complete ONLY if you accepted a check or electronic transaction authorization at time of application for the initial premium. **DO NOT** complete the Conditional Receipt if initial payment won't be collected until issue.
- ❑ Accelerated Benefit Rider Disclosure – The client must sign the Accelerated Benefit Rider Disclosure Form
- ❑ Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor - Complete this form if applicable. The client must sign and retain a copy for their records.

Supplemental Forms and Buyer's Guide:

- ***Buyer's Guide:*** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale.

United of Omaha Life Insurance Company

A Mutual of Omaha Company

Mutual of Omaha Plaza, Omaha, NE 68175

Application for Individual Life Insurance

PROPOSED INSURED

Name (First, Middle Initial, Last)	Sex ☐ Male ☐ Female	Height	Weight	Social Security No.

Home Address (Street, City, State, Zip)	State of Birth	Date of Birth	Age

Phone No.	E-mail	Driver's License No.	Driver's License State

Are you a legal resident of the United States? ☐ **Yes** ☐ **No**
(If "No", you are not eligible for coverage.)

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

(Optional)- Secondary Addressee: To help make sure your policy stays in force, you can have the person listed below receive a notice when your policy is past due and has not been paid.
Name _____ Address _____ Phone No. _____

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

Name of Policyowner (First, Middle Initial, Last)	Relationship to Proposed Insured

Policyowner Address (Street, City, State, Zip)	Phone No.	Social Security No.

Sex ☐ Male ☐ Female	Date of Birth	Age	E-mail	Citizenship Country

UNDERWRITING

Part One **IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN PART ONE, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.**

1. Is the Proposed Insured currently:
- **(a)** bedridden or confined to any hospital, nursing home, long-term care facility or skilled nursing facility; or receiving or been advised to receive care in a nursing home, hospice care, or home health care? . . . . ☐ **Yes** ☐ **No**
- **(b)** requiring assistance with activities of daily living such as taking medications, bathing, dressing, eating, toileting, getting in and out of a chair or bed, or control of bowel or bladder problems? . . . . . ☐ **Yes** ☐ **No**
- **(c)** requiring any of the following (other than for fractures, bone or joint surgery, including replacement): wheelchair, electric scooter, or oxygen equipment to assist breathing (excluding use for sleep apnea)? . . . . . ☐ **Yes** ☐ **No**

2. Has the Proposed Insured **ever been**:
- **(a)** diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or been treated for AIDS or ARC by a physician or heath care provider? . . . . . ☐ **Yes** ☐ **No**
- **(b)** diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Quadriplegia, Paraplegia, Down's Syndrome, mental incapacity, congestive heart failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type? . . . . . ☐ **Yes** ☐ **No**
- **(c)** diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed with End Stage Renal Disease or requiring dialysis?. . . . . ☐ **Yes** ☐ **No**
- **(d)** advised to receive or have received an organ or bone marrow transplant?. . . . . ☐ **Yes** ☐ **No**
- **(e)** diagnosed by a physician or health care provider as having a terminal medical condition that is expected to result in death within the next 12months?. . . . . ☐ **Yes** ☐ **No**

3. In the past 12 months, has the Proposed Insured been:
- **(a)** advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known? . . . . . ☐ **Yes** ☐ **No**
- **(b)** diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind? . . ☐ **Yes** ☐ **No**

4. In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for any form of cancer (except basal or squamous cell skin cancer)? . . . . . ☐ **Yes** ☐ **No**

Part Two **IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTION IN PART TWO, THAT PERSON IS ELIGIBLE ONLY FOR THE GRADED BENEFIT PRODUCT.**

5. 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:	
(a) Diabetes before age 50 or diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)?	☐ **Yes** ☐ **No**
(b) Hepatitis C?	☐ **Yes** ☐ **No**
(c) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?	☐ **Yes** ☐ **No**
6. In the past 4 years, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)?	☐ **Yes** ☐ **No**
(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?	☐ **Yes** ☐ **No**
(c) Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis?	☐ **Yes** ☐ **No**
7. In the past 2 years, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement?	☐ **Yes** ☐ **No**
(b) Stroke or Transient Ischemic Attack (TIA)?	☐ **Yes** ☐ **No**
8. In the past 2 years, has the Proposed Insured:	
(a) been convicted of, incarcerated for or currently awaiting trial for a felony?	☐ **Yes** ☐ **No**
(b) been treated for or advised to have treatment for alcohol or drug abuse or convicted more than once of reckless driving or driving under the influence of drugs or alcohol?	☐ **Yes** ☐ **No**
(c) used unlawful drugs in any form or abused or misused prescription drugs?	☐ **Yes** ☐ **No**
9. In the past 2 years, has the Proposed Insured been hospitalized by a physician or health care provider for any mental or nervous disorder?	☐ **Yes** ☐ **No**
10. In the past 12 months, has the Proposed Insured consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding?	☐ **Yes** ☐ **No**

NOTE: If the Proposed Insured answers all above questions "No", that person is eligible for the Level Benefit Product.

OPTIONAL COMMENTS (Not Required) - Provide any additional information available.

Question Number	Details to Underwriting Questions (Diagnosis, Dates, Durations, Medications, Dosages)

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PLAN INFORMATION

Plan:

☐ Level Benefit Product ☐ Graded Benefit Product

Amount Applied For $ _____

Payment Mode:

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (Automated Bank Account Withdrawal)

Modal Premium $_____ Collected Premium $_____

BENEFICIARY (If more space is needed, list on a separate sheet)

Primary Beneficiary	Relationship to Insured	Date of Birth
Contingent Beneficiary	Relationship to Insured	Date of Birth

OTHER COVERAGE INFORMATION

1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company? . . . . . ☐ **Yes** ☐ **No**

2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with the company or any other company? . . . . . ☐ **Yes** ☐ **No**

If "Yes" to questions #1 or #2, please give details below. If more space is needed, list on a separate sheet.

Company	Proposed Insured	Face Amount	To be Replaced or Converted?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

AUTHORIZATION and AGREEMENT

Authorization: I authorize any medical provider, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical care facility, MIB, Inc. (MIB), state department of motor vehicles and other entities processing motor vehicle records, insurance companies or consumer reporting agencies to release information about me or my health, such as, medical history, including the presence of HIV infection, AIDS or ARC, mental or physical condition, prescription drug records, drug or alcohol use, driving record or insurance claims information, to United of Omaha Life Insurance Company ("United of Omaha"). The information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise. I also authorize United of Omaha to disclose information to MIB. I understand that my information received by MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations. This authorization is valid for 24 months from the date signed. I may refuse to sign this authorization but if I refuse, the insurance I am applying for will not be issued. I may revoke this authorization at any time by written notice to the address below. This revocation is limited to the extent that United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha to contest the issuance of the policy or a claim under the policy. I will receive a copy of this authorization.

Agreement: I represent the information above is true and complete, to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy effective the issue date. Unless otherwise provided under a conditional receipt, I understand that no insurance shall take effect until all outstanding application requirements have been received, a policy is issued and the first premium is received by United of Omaha during the Proposed Insured's lifetime. The issue date of the policy will be the date shown on the policy, even though coverage may not become effective until a later date. You must immediately notify United of Omaha if there has been a change in the Proposed Insured's health or habits that will change any statement or answer to any question in the application as of the date the policy is delivered. No policy of any kind will be in effect if the Proposed Insured dies or is otherwise ineligible for the insurance for which they applied. No producer can waive or change any receipt or policy provision or agree to issue any policy.

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- CONTINUED ON NEXT PAGE -

If applying for the Graded Benefit Product: I understand that a reduced death benefit amount is payable during the first two policy years if death results from sickness or other natural causes. The full face amount is payable during the first two policy years if death results from an accident.

Signed at: _____
City State

_____ Date: _____
Signature of Proposed Insured

_____ Date: _____
Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)

Producer Statement:

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.

1. 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**
2. Do you, the Producer(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy or annuity contract in force with the company or any other company? . . . . . ☐ **Yes** ☐ **No**
3. Has the Proposed Insured informed you, the Producer(s), that he/she has any pending or existing life insurance or annuity contracts with the company or any other company?. . . . . ☐ **Yes** ☐ **No**

(If the above questions are answered "Yes," fulfill all state and company requirements.)

4. Are you related to the Proposed Insured or Owner? . . . . . ☐ **Yes** ☐ **No**

If "Yes," state relationship _____

5. How long have you known the Proposed Insured? _____
6. How long have you known the Proposed Owner? _____
7. Previous residence of Proposed Insured for the past five years.

Street Address	City	State	Zip Code

8. I/We conducted said interview in person . . . . . ☐ **Yes** ☐ **No**

If "No," please explain _____

_____ _____ _____ _____
Signature of Producer #1 Producer E-mail Production Number Date

_____ _____ _____ _____
Signature of Producer #2 Producer E-mail Production Number Date

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

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Producer Report

1 Was a Personal Health Interview (PHI) conducted by Apptical Corporation as a part of the application process?.....☐ Yes ☐ No

If Yes, please provide the PHI number_____

2 List any additional information or comments below:

_____

_____

_____

_____

_____

_____

_____

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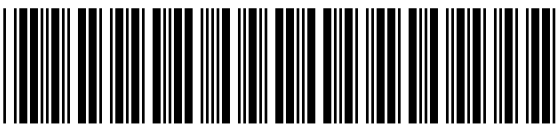


United of Omaha Life Insurance Company

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

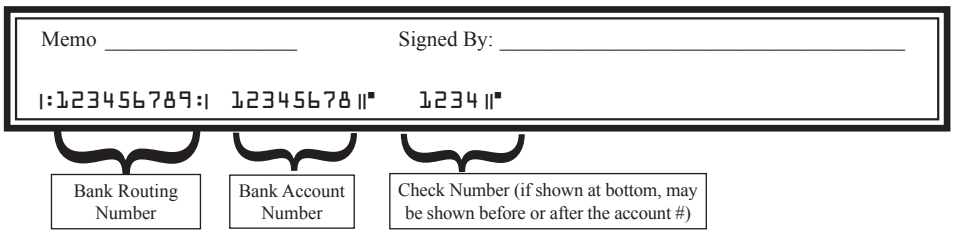
☐ Other _____

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)



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

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

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

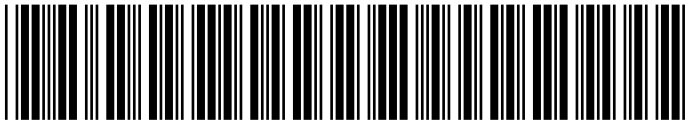
_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

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

I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We 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



ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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

This rider is not a long term care policy as defined in section 10231.2 of the California Insurance Code.

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness 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 the insured has a terminal illness, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. A physician must sign a statement of proof that the insured has a terminal illness.

The amount available for the accelerated death benefit is your policy's death benefit reduced by 6%. We will also deduct a $100 administrative charge and the amount of any loans and unpaid premiums.

You may receive the accelerated death benefit only once.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The policy will terminate when the accelerated death benefit is paid.

NOTE: If the policy is issued as a graded death benefit, the accelerated death benefit is not available.

Acknowledgment

I acknowledge receipt of this disclosure form.

_____ _____
Applicant/Owner Signature Date

I have provided this disclosure form to the applicant/owner.

_____ _____
Producer Signature Date

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

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

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

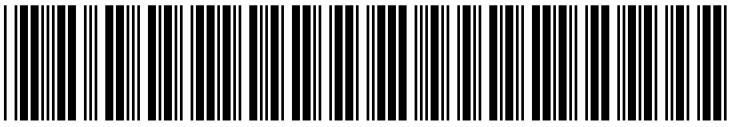
_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

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

I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We 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



ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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

This rider is not a long term care policy as defined in section 10231.2 of the California Insurance Code.

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness 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 the insured has a terminal illness, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. A physician must sign a statement of proof that the insured has a terminal illness.

The amount available for the accelerated death benefit is your policy's death benefit reduced by 6%. We will also deduct a $100 administrative charge and the amount of any loans and unpaid premiums.

You may receive the accelerated death benefit only once.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The policy will terminate when the accelerated death benefit is paid.

NOTE: If the policy is issued as a graded death benefit, the accelerated death benefit is not available.

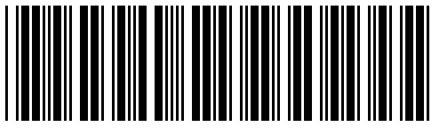
Acknowledgment

I acknowledge receipt of this disclosure form.

_____ _____
Applicant/Owner Signature Date

I have provided this disclosure form to the applicant/owner.

_____ _____
Producer Signature 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. 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

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

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

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.

If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months? . . . ❑ YES ❑ NO

Applicant's/Owner's Signature	Date	Agent's Signature

L4748_0803

Company's Copy

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.

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

If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months? . . . ❑ YES ❑ NO

Applicant's/Owner's Signature	Date	Agent's Signature

Applicant's/Owner's Copy

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.

_____

_____

_____

_____

_____

_____

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 $120,900 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 $3,023 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 $120,900 in countable resources. The order also may allow the at-home spouse to retain more than $3,023 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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(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.

Living Promise Whole Life Insurance
PREMIUM CALCULATOR

Level Benefit Plan Annual Premiums per $1,000 of Coverage

Age	Male		Female		Age	Male		Female	
	NonTobacco	Tobacco	NonTobacco	Tobacco		NonTobacco	Tobacco	NonTobacco	Tobacco
45	$24.99	$31.50	$21.80	$28.02	66	$63.08	$91.34	$45.21	$63.30
46	$25.81	$32.58	$22.27	$28.74	67	$67.11	$97.65	$47.93	$67.27
47	$26.76	$33.91	$22.86	$29.58	68	$71.15	$103.85	$50.66	$71.24
48	$27.82	$35.35	$23.57	$30.42	69	$75.18	$110.04	$53.49	$75.22
49	$28.45	$36.37	$23.91	$31.04	70	$79.21	$116.35	$56.22	$79.19
50	$29.16	$37.85	$24.12	$31.71	71	$84.44	$124.53	$60.03	$84.92
51	$30.45	$40.09	$25.00	$33.36	72	$89.57	$132.83	$63.95	$90.52
52	$31.37	$41.91	$25.48	$34.43	73	$95.29	$141.12	$68.23	$96.25
53	$32.58	$44.25	$26.31	$36.07	74	$101.07	$149.30	$72.56	$101.86
54	$34.16	$46.70	$27.26	$37.59	75	$108.23	$157.60	$77.76	$107.58
55	$35.83	$49.51	$28.31	$39.46	76	$116.48	$168.00	$84.32	$115.06
56	$37.36	$51.96	$29.29	$40.86	77	$124.09	$179.26	$90.23	$123.14
57	$38.99	$54.30	$30.17	$42.15	78	$131.07	$190.75	$95.77	$131.28
58	$40.52	$56.64	$31.04	$43.43	79	$138.23	$202.21	$101.36	$139.50
59	$42.26	$59.44	$32.02	$44.83	80	$145.45	$213.78	$107.00	$147.79
60	$44.44	$62.71	$33.33	$46.59	81	$157.07	$232.47	$115.74	$159.70
61	$47.39	$67.15	$35.18	$49.16	82	$168.92	$252.48	$124.44	$172.55
62	$50.22	$71.71	$36.92	$51.73	83	$180.01	$272.67	$132.70	$185.39
63	$53.16	$76.15	$38.78	$54.30	84	$191.10	$291.55	$140.84	$197.41
64	$56.11	$80.71	$40.63	$56.75	85	$202.19	$310.54	$149.10	$209.55
65	$59.05	$85.15	$42.48	$59.32					

Follow these steps to calculate premium.	**Example** (Male, age 60, Nontobacco, needs $10,000 of coverage)	**My Living Promise** Benefit $_____
1. Divide the desired death benefit amount by 1,000. (Minimum $2,000; maximum $40,000)	1. **10**	_____
2. Locate the rate chart for the plan you chose. Look for your age group and tobacco user status. Identify the premium rate per thousand.	2. **$44.44**	$_____
3. Multiply #1 by #2 above.	3. **$444.40**	$_____
4. Add policy fee of $36.	4. **$480.40 Annual Premium**	$_____
5. Payment Options: Multiply annual premium by: • 0.089 for monthly bank draft • 0.275 for quarterly • 0.52 for semiannual	5. Monthly **$42.76** Quarterly **$132.11** Semiannual **$249.81**	$_____ $_____ $_____

Whole Life Insurance is underwritten by United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. United of Omaha is licensed in all states except NY. Product base plans, provisions, features, and riders may not be available in all states and may vary by state.

Accidental Death Benefit Rider Annual Unisex Premiums per $1,000 of Coverage (Level Benefit Plan only)

Age	Premium	Age	Premium
45	$2.77	66	$4.13
46	$2.80	67	$4.38
47	$2.82	68	$4.61
48	$2.83	69	$4.84
49	$2.84	70	$5.11
50	$2.85	71	$5.44
51	$2.86	72	$5.82
52	$2.88	73	$6.34
53	$2.89	74	$6.92
54	$2.92	75	$7.57
55	$2.94	76	$8.26
56	$2.97	77	$9.00
57	$3.00	78	$9.77
58	$3.08	79	$10.59
59	$3.16	80	$11.46
60	$3.25	81	$12.35
61	$3.36	82	$13.26
62	$3.48	83	$14.44
63	$3.62	84	$15.68
64	$3.77	85	$16.97
65	$3.93		

Follow these steps to calculate premium with the AD rider.	**Example** (Male, age 60, Nontobacco, needs $10,000 of coverage)	**My Living Promise with AD Rider** Benefit $_____
1. Carry the Annual Premium (#4) from front page.	1. **$480.40**	_____
2. Locate the rate for the rider. Identify the premium rate per thousand.	2. **$3.25**	$_____
3a. Carry the desired death benefit from #1 on front page. Multiply #2 by #3a.	3a. **10** 3b. **$32.50**	$_____
4. Add #3b to #1.	4. **$480.40 + 32.50 =** **$512.90 Annual Premium**	$_____
5. Payment Options: Multiply annual premium by: • 0.089 for monthly bank draft • 0.275 for quarterly • 0.52 for semiannual	5. Monthly **$45.65** Quarterly **$141.05** Semiannual **$266.71**	 $_____ $_____ $_____

Graded Benefit Plan Annual Premiums per $1,000 of Coverage

Age	Male	Female	Age	Male	Female	Age	Male	Female	Age	Male	Female
45	$43.61	$35.71	54	$60.50	$47.00	63	$93.75	$64.00	72	$153.25	$111.00
46	$44.50	$36.43	55	$63.75	$48.50	64	$98.75	$66.75	73	$165.25	$120.50
47	$45.42	$37.18	56	$67.00	$50.25	65	$103.00	$69.50	74	$176.25	$129.25
48	$46.34	$37.93	57	$70.25	$52.00	66	$108.50	$73.75	75	$187.50	$138.75
49	$47.29	$38.71	58	$73.75	$53.00	67	$114.25	$79.00	76	$206.75	$151.75
50	$48.25	$39.50	59	$77.00	$54.75	68	$119.75	$83.25	77	$225.25	$164.75
51	$51.50	$41.00	60	$80.25	$56.50	69	$125.50	$88.50	78	$244.25	$177.00
52	$54.75	$43.25	61	$84.50	$59.25	70	$131.00	$92.75	79	$262.75	$190.00
53	$57.25	$44.75	62	$89.50	$62.00	71	$142.25	$102.25	80	$282.00	$203.00

Follow these steps to calculate premium.	**Example** (Male, age 60, needs $10,000 of coverage)	**My Living Promise** Benefit $_____
1. Divide the desired death benefit amount by 1,000. (Minimum $2,000; maximum $20,000)	1. **10**	_____
2. Locate the rate chart for the plan you chose. Look for your age group and tobacco user status. Identify the premium rate per thousand.	2. **$80.25**	$_____
3. Multiply #1 by #2 above.	3. **$802.50**	$_____
4. Add policy fee of $36.	4. **$838.50 Annual Premium**	$_____
5. Payment Options: Multiply annual premium by: • 0.089 for monthly bank draft • 0.275 for quarterly • 0.52 for semiannual	5. Monthly **$74.63** Quarterly **$230.59** Semiannual **$436.02**	 $_____ $_____ $_____

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)**