# CALIFORNIA – Application for Life Insurance

*FULLY UNDERWRITTEN PRODUCTS – One Base Policy Per Application*

**Checklist for Submitting a Complete Application**

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

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

| PRODUCTS | OPTIONAL RIDERS |
|---|---|
| ❑ Term Life Answers (TLA) | ❑ Disability Waiver of Premium Rider<br>❑ Other Insured Rider<br>❑ Dependent Children's Rider ($1,000 - $10,000)<br>❑ Accidental Death Benefit Rider |
| ❑ AccumUL Answers<br>❑ Income Advantage (IUL)<br>❑ Life Protection Advantage (IUL) | ❑ Disability Waiver of Policy Charges<br>❑ Disability Continuation of Planned Premium Rider<br>❑ Guaranteed Insurability Rider ($10,000-$50,000)<br>❑ Dependent Children's Rider ($1,000 - $10,000)<br>❑ Accidental Death Benefit Rider<br>❑ Additional Insured Term Rider - Self & Other Insured |

## APPLICATION SUBMISSION GUIDELINES

- ❑ Attach a cover letter or additional information as needed, AND Always submit the Producer Statement and Producer Report page
- ❑ Always obtain signed HIPAA/MIB authorization
- ❑ Leave all applicable forms and Life Insurance Buyer's Guide with the Proposed Insured
- ❑ All changes should be initialed and dated by the Applicant/Owner
- ❑ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client
- ❑ If selecting the Disability Continuation of Planned Premium Rider, Guaranteed Insurability Rider, Accidental Death Benefit Rider, Dependent Children's Rider, Additional Insured Term Rider or the Other Insured Rider, a **RIDER AMOUNT** must be entered on the application.

## IMPORTANT FORMS

- ❑ Replacement Notice – If applicable, the client must sign and retain a copy for their records
- ❑ Payment Authorization – Complete this form if applicable
- ❑ Complete two copies of the TIA form and leave the unsigned copy with the applicant when: a) all 6 questions on the TIA are answered "no"; and b) a check or electronic transaction authorization for the initial premium is collected. **DO NOT** collect a check if any of the 6 TIA questions are answered "yes" - a completed electronic transaction authorization may still be submitted. **DO NOT** complete the TIA if initial payment won't be collected until issue.
- ❑ You will need a signed Accelerated Death Benefit Rider Disclosure Form
- ❑ If face amount is $100,000 or over, you will need a signed HIV consent form
  (If your state does not require the HIV Consent form, then this form will not be included in this application package)
- ❑ If face amount is $1,000,000 and above and the Proposed Insured is age 65, or over you will need: (a) signed Statement of Policyowner form and, (b) signed Premium Funding and Acknowledgement form
- ❑ Federal Form F4506T-EZ - Used to request tax records for the insured. This form is required for applications with a face amount of greater than $5 million and may be requested by underwriting as necessary.

## SUPPLEMENT APPLICATIONS, FORMS & BUYER'S GUIDE

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

| PARAMEDICAL VENDORS | INDICATE UNDERWRITING REQUIREMENTS INITIATED OR COMPLETED ON THE PROPOSED INSURED(S) | |
|---|---|---|
| **APPS** – 1-800-635-1677<br>**EXAMONE** – 1-877-933-9261 | **Primary Proposed Insured**<br>☐ Blood Profile ☐ Urinalysis<br>☐ Physical Data ☐ MD Exam<br>☐ Long Form Exam ☐ EKG<br>☐ Treadmill EKG | **Other Proposed Insured:**<br>☐ Blood Profile ☐ Urinalysis<br>☐ Physical Data ☐ MD Exam<br>☐ Long Form Exam ☐ EKG<br>☐ Treadmill EKG |

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3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# INDIVIDUAL LIFE INSURANCE APPLICATION PART 1, PAGE 1 OF 4

| **PROPOSED INSURED** (If Proposed insured is age 0-17, complete the Juvenile Supplemental Application) | | | |
|---|---|---|---|
| Name (First, Middle Initial, Last) | | Social Security Number | Gender at Birth ☐ Male ☐ Female |
| Home Address (Street, City, State, ZIP) | | | Marital Status |
| Primary Phone No. | Secondary Phone No. | E-mail | |
| Driver's License No.(If none, please explain) | | | Driver's License State |
| Occupation/Duties | | Annual Income | Employer |
| Date of Birth | State of Birth (Country if not U.S.) | U.S. Citizen?.... ☐ **Yes** ☐ **No** **(If No, complete the Foreign National and Foreign Travel questionnaire)** | |
| Have you ever used any form of tobacco or any form of nicotine replacement therapy?.. ☐ **Yes** ☐ **No** Date Stopped_____ month/year **(If Yes, provide details in the Comments section.)** | | | |

| **PROPOSED INSURED BENEFICIARY** (IF MORE SPACE IS NEEDED, USE THE COMMENTS SECTION) | | | |
|---|---|---|---|
| Primary Beneficiary | % of Proceeds | Date of Birth | Relationship to Proposed Insured |
| Contingent Beneficiary | % of Proceeds | Date of Birth | Relationship to Proposed Insured |

| **OTHER PROPOSED INSURED** (If Other Proposed insured is age 0-17, complete the Juvenile Supplemental Application) | | | |
|---|---|---|---|
| Name (First, Middle Initial, Last) | | Social Security Number | Gender at Birth ☐ Male ☐ Female |
| Home Address (Street, City, State, ZIP) | | | Relationship to Proposed Insured |
| Primary Phone No. | Secondary Phone No. | E-mail | |
| Driver's License No.(If none, please explain) | | | Driver's License State |
| Occupation/Duties | | Annual Income | Employer |
| Date of Birth | State of Birth (Country if not U.S.) | U.S. Citizen?.... ☐ **Yes** ☐ **No** **(If No, complete the Foreign National and Foreign Travel questionnaire)** | |
| Have you ever used any form of tobacco or any form of nicotine replacement therapy?.. ☐ **Yes** ☐ **No** Date Stopped_____ month/year **(If Yes, provide details in the Comments section.)** | | | |

| **OTHER PROPOSED INSURED BENEFICIARY** (IF MORE SPACE IS NEEDED, USE THE COMMENTS SECTION) | | | |
|---|---|---|---|
| Primary Beneficiary | % of Proceeds | Date of Birth | Relationship to Insured |
| Contingent Beneficiary | % of Proceeds | Date of Birth | Relationship to Insured |

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## OWNER (Complete Policyowner Information if Proposed Insured is not the Policyowner)

Owner Is: ☐ Individual ☐ Employer ☐ Trust ☐ Other (Specify): _____

| Name of Policyowner (First, Middle Initial, Last) | Relationship to Proposed Insured | Social Security No./Tax ID |
|---|---|---|
| | | |

| Policyowner Address (Street, City, State, ZIP) | Date of Birth/Date of Trust |
|---|---|
| | |

| Policyowner Phone No. | Policyowner E-mail |
|---|---|
| | |

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

Name_____ Phone Number_____

Address_____

Street City State ZIP

## PLAN INFORMATION

**RISK/RATE CLASS APPLIED FOR:**

☐ Standard or Best Available Risk Class

☐ Substandard Risk Class Proposed: Table _____

**TERM LIFE PLAN AMOUNT OF INSURANCE APPLIED FOR: $**_____

| Product Selection | Optional Riders |
|---|---|
| ☐ Term Life Answers (TLA) 10-Year Term Life | ☐ Disability Waiver of Premium |
| ☐ Term Life Answers (TLA) 15-Year Term Life | ☐ Other Insured Rider: $_____ |
| ☐ Term Life Answers (TLA) 20-Year Term Life | ☐ Dependent Children's Rider: $_____ |
| ☐ Term Life Answers (TLA) 30-Year Term Life | ☐ Accidental Death Benefit Rider: $_____ |

**UNIVERSAL LIFE PLAN AMOUNT OF INSURANCE APPLIED FOR: $**_____

| Product Selection | Death Benefit (pick one) | Optional Riders |
|---|---|---|
| ☐ Income Advantage (IUL)<br>☐ Life Protection Advantage (IUL)<br>☐ Other: _____ | ☐ UL Option 1 Level Death Benefit<br>☐ UL Option 2 Specified Amount plus Accumulation Value | ☐ Disability Waiver of Policy Charges<br>☐ Disability Continuation of Planned Premium Rider: $_____<br>☐ Guaranteed Insurability Rider: $_____<br>☐ Dependent Children's Rider: $_____<br>☐ Accidental Death Benefit Rider: $_____<br>☐ Additional Insured Term Rider (Self): $_____<br>☐ Additional Insured Term Rider (Other Insured): $_____ |
| ☐ AccumUL Answers | ☐ UL Option 1 Level Death Benefit<br>☐ UL Option 2 Specified Amount plus Accumulation Value | ☐ Disability Waiver of Policy Charges<br>☐ Disability Continuation of Planned Premium Rider: $_____<br>☐ Guaranteed Insurability Rider: $_____<br>☐ Dependent Children's Rider: $_____<br>☐ Accidental Death Benefit Rider: $_____<br>☐ Additional Insured Term Rider (Self): $_____<br>☐ Additional Insured Term Rider (Other Insured): $_____ |

## PREMIUM INFORMATION

| | |
|---|---|
| **Premium Method** | ☐ Direct Bill ☐ Bank Draft *(Monthly Only) (Complete Payment Authorization Form)*<br>☐ Other *(Please Explain)* _____ |
| **Frequency of Modal Premium** | ☐ Monthly *(Bank Draft Only)* ☐ Annual ☐ Semi-Annual ☐ Quarterly |
| Modal Premium $_____<br>Collected Premium $_____ | **Proposed Insured** / **Other Proposed Insured**<br>Date Policy to Save Age? . . . . . ☐ **Yes** ☐ **No** / ☐ **Yes** ☐ **No** |

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## Insurance History

1. Have you been offered cash, or any other consideration for obtaining this policy? ☐ Yes ☐ No
2. Are you planning to enter into a finance arrangement to pay any premium payments due under this policy? ☐ Yes ☐ No
3. Do you intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? ☐ Yes ☐ No
   **(If Yes to questions 1, 2 or 3, provide information in Comments section.)**
4. In the past 12 months, have you applied for any life insurance or do you have any life insurance currently pending, excluding this application? ☐ Yes ☐ No
5. Do you have any existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No
6. Will this insurance replace or change any existing life insurance or annuity contract with the company or any other company? ☐ Yes ☐ No
   **(If Yes to questions 4, 5 or 6, complete the boxes below.)**
   **The Producer shall comply with any additional state, and/or Company replacement requirements.**

| Person Proposed for Insurance | Company | Face Amount | Replaced/ Converted? | Pending? | 1035 Exchange? | Business or Personal | Year Issued |
|---|---|---|---|---|---|---|---|
| | | | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | | |
| | | | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | | |
| | | | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | | |
| | | | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | | |
| | | | ☐Yes ☐No | ☐Yes ☐No | ☐Yes ☐No | | |

## Proposed Insured(s) History

| 1. Have you: (If answered Yes, please explain your answer in the Comments section.) | Proposed Insured | Other Proposed Insured |
|---|---|---|
| (a) had life insurance coverage declined, postponed or limited, or been denied reinstatement or asked to pay extra premium by any insurance company? **(If Yes, please provide details of decision type, reason and date in Comments section.)** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (b) engaged in parachuting, hang gliding, rock or mountain climbing, skydiving, SCUBA diving, cliff diving, organized vehicle or boat racing, BASE or bungee jumping within the last three years or plan such activity in the next two years? **(If Yes, complete the appropriate questionnaire.)** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (c) any plan of traveling or living outside the USA or Canada in the next two years? **(If Yes, complete the Foreign National and Foreign Travel questionnaire.)** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (d) flown as a civilian pilot, student pilot or crew member within the last three years or plan such activity in the next two years? **(If Yes, complete the Aviation questionnaire.)** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (e) within the last five years been convicted of two or more moving violations, been convicted of driving under the influence of alcohol or drugs or had a driver's license suspended or revoked? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (f) been convicted of a felony or have been incarcerated within the last 10 years? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (g) been on probation within the last 12 months or are currently on probation? | ☐ Yes ☐ No | ☐ Yes ☐ No |

## Comments

Provide any additional information necessary and the details of Yes answers. Identify the question number if applicable. Use an additional sheet of paper if necessary.

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## FINANCES (COMPLETE EITHER THE PERSONAL OR BUSINESS SECTION)

**Personal:**

1. Purpose of Insurance:
   ☐ Income Replacement ☐ Debt Repayment ☐ Estate Conservation ☐ Other (Specify): _____
2. Personal Finances: Gross Annual Income $_____ Total Assets $ _____ Total Liabilities $ _____
3. Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you?. . . ☐ **Yes** ☐ **No**
   **If Yes, please explain and provide the filing and discharge dates**_____

**Business:** Please attach a copy of your Company's latest financial statements (Balance Sheet and Profit and Loss). If not available, complete the following questions:

1. Purpose of Insurance:
   ☐ Buy-Sell: Type of Agreement: ☐ Entity/Stock Redemption ☐ Cross Purchase ☐ Wait-and-See
   ☐ Key Person: Explanation of special skills/relationships to the business _____
   _____
   ☐ Other: Please Explain_____
2. Proposed Insured's Salary (include bonus) $_____
3. Company Book Value $_____ Company Market Value $_____
   Proposed Insured's % Ownership $_____Market Value of Proposed Insured's Ownership $_____
4. Business Insurance Carried by Other Owners, Officers, Partners or Key Persons:

| Name | Title and Interest | Amounts Now Carried and Company | Amount Now Applied For and Company |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

5. Within the past 5 years, has the business filed for bankruptcy or had any judgments or liens filed against it? . . ☐ **Yes** ☐ **No**
   **If Yes, please explain and provide filing and discharge dates**_____

## AGREEMENT

**Agreement:** I represent the information above is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers will not void this application and any issued policy effective the issue date unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. Unless otherwise provided under a temporary insurance agreement, 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.

This application includes Part 1, Part 2 and/or the Statements to Examiner as well as all approved supplemental forms or amendments the Insurer specifically designates as parts of the application, by attaching as part of any policy delivered to the Owner.

Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage.

Signed at: _____ _____ Date _____
City State Mo Day Yr

_____ _____
Signature of Proposed Insured Age 15 and Over

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

_____ _____
Signature of Other Proposed Insured Age 15 and Over

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

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

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3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 1 OF 3

## Proposed Insured(s) Information

| | |
|---|---|
| Name of Proposed Insured_____ | Name of Other Proposed Insured_____ |
| Date of Birth_____ | Date of Birth_____ |
| Height _____ft. _____in. Weight _____lbs. | Height _____ft. _____in. Weight _____lbs. |

## Physician Information

| Person Proposed for Insurance | Name, Address and Telephone Number of Personal Physician | Date Last Seen | State Reason, Findings and Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Family History

| | Proposed Insured | Other Proposed Insured |
|---|---|---|
| Do you have a deceased parent(s) and/or sibling(s)? . . . . . **(If Yes, please list details below. If more space is needed, use the Comments section.)** | ☐ Yes ☐ No | ☐ Yes ☐ No |

| | Age at Death | Cause of Death | Age at Death | Cause of Death |
|---|---|---|---|---|
| | Proposed Insured | Proposed Insured | Other Proposed Insured | Other Proposed Insured |
| Father | | | | |
| Mother | | | | |
| Sibling 1 | | | | |
| Sibling 2 | | | | |
| Sibling 3 | | | | |

## Medical History

| | Proposed Insured | Other Proposed Insured |
|---|---|---|
| **1.** Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or health care provider?. . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **2. In the past 15 years**, have you (a) received treatment for, or (b) had a member of the medical profession tell you to seek treatment regarding: | | |
| **(a)** any disease, or condition of the heart, circulatory system, or blood vessels, including but not limited to high blood pressure, irregular heart rhythm, pacemaker or defibrillator, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke? . . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(b)** any disease of the lungs, or respiratory system, including but not limited to tuberculosis, asthma, chronic bronchitis, emphysema, sleep apnea or shortness of breath? . . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(c)** any digestive system disease, including but not limited to ulcer, hepatitis, cirrhosis, colitis, or other colon, intestinal condition or any other disease of the esophagus, liver, stomach, gallbladder, intestines or rectum? . . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(d)** any urinary, or reproductive system disease including but not limited to protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries? . . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(e)** any brain, nerve, or mental condition, including but not limited to convulsions/ epilepsy, headaches, blackouts, tremors, balance conditions, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?. . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(f)** any bone, or joint condition, arthritis, or rheumatic conditions, including but not limited to lupus, rheumatoid arthritis, scleroderma, fibromyalgia, amputation, back, or spinal condition? . . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(g)** any disease of the eyes or ears? . . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(h)** cancer, tumor, blood/bleeding condition, diabetes, thyroid, or other glandular/ metabolic condition?. . . . . | ☐ Yes ☐ No | ☐ Yes ☐ No |

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## MEDICAL HISTORY CONTINUED

| | Proposed Insured | Other Proposed Insured |
|---|---|---|
| **3. In the past 10 years,** have you: | | |
| **(a)** used alcohol or drugs to a degree that required inpatient or outpatient treatment or counseling, or been advised to limit, or discontinue its use by a member of the medical profession? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(b)** used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **4. In the past 12 months**, have you: | | |
| **(a)** required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(b)** received, or been advised by a member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(c)** used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(d)** applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **(e)** had an unexplained weight loss of greater than 10 pounds (other than due to diet or exercise)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **5.** In the past two years, have you (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**(If Yes, please list details below. If more space is needed use the Comments section.)**

| Person Proposed for Insurance | Medication Name (copy from pharmacy label) | Date Last Taken | Prescribing Physician (if any) | Reason | Dosage/ Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | Proposed Insured | Other Proposed Insured |
|---|---|---|
| **6.** In the past five years, have you consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? | ☐ Yes ☐ No | ☐ Yes ☐ No |

(**If Yes, please list details below. If more space is needed use the Comments section.**)

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

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## INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 3 OF 3

### Comments

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

### Agreement

I represent the information in this application is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers will not void this application and any issued policy effective the issue date unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage.

Signed at: _____ _____ Date _____
City State Mo Day Yr

_____ _____
Signature of Proposed Insured Age 15 and Over Signature of Parent or Guardian if Proposed Insured is under Age 15

_____
Signature of Other Proposed Insured Age 15 and Over

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## Producer Statement

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

_____

**2.** Do you, the Producer(s), know or have reason to believe that the policy(ies) applied for has replaced or will replace any existing life insurance policies or annuity contracts? . . . . . ☐ **Yes** ☐ **No**

**3.** Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer's Guide and comply with all state and Company replacement requirements? ☐ **Yes** ☐ **No** **If "No," please explain** _____

_____

_____

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

_____

_____

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

_____

_____

_____ _____ _____
Signature of Producer # 1 Production Number Mo Day Yr

_____ _____ _____
Signature of Producer # 2 Production Number Mo Day Yr

_____
Print or Stamp Producer #1 Name

_____
Print or Stamp Producer #2 Name

_____ _____
General Agent/General Manager Name General Agent/General Manager Stamp

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**PLEASE SUBMIT ALL PAGES**

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

## Producer's Report

**(Must be completed by the Producer who obtained the application on the Proposed Primary Insured named below.)**

**1** Is Proposed Primary Insured self-supporting? ❑ Yes ❑ No

If "No," provide the following information about the person on whom Proposed Primary Insured is dependent:

Full Name _____ Address _____ Birth Date _____

Amount of life insurance carried with all companies $ _____ If none, state why_____

**2** If Proposed Primary Insured used a different name in past, give previous different full name(s) _____

_____

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

**4** How long have you known the Proposed Primary Insured? _____

**5** How long have you known the Proposed Owner? _____

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

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

_____

_____

_____

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

_____

_____

_____

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

**9** Rate class quoted _____

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

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

| Address | From | To |
|---|---|---|
| | | |
| | | |
| | | |

**Additional Comments**

_____

_____

_____

# 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 for withdrawal for a premium payment.**

### Payment Information For The First Payment- Can Be Different Than The Ongoing Payments

**Initial Premium Payment (select only one option)** Amount Quoted $ _____

- ☐ Deduct premium immediately upon approval/issue
- ☐ Deduct initial premium on or after: _____/_____/_____ (Please Note: If the policy issue is after the date selected, the initial payment will be deducted on the date the policy is issued or all delivery requirements are received.)
- ☐ Check collected and mailed to Mutual of Omaha

Money will be deducted from your account as stated above. The first deduction may occur on a date different than the ongoing payments. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first deduction may exceed one regular payment amount. We **CANNOT** establish electronic payments from foreign banks.

### Payment Information For Ongoing Payments- Automatic Bank Account Deduction

**Ongoing Automatic Monthly Premium Payments (Once a Month)- Select only one option**

- ☐ Choose the day payments will be deducted every month from your bank account:
  (**1st through the 28th** or **Last Day** of every month) _____

-OR-

- ☐ Choose the week and weekday that payments will be deducted every month from your bank account:
  (For example, 3rd Wednesday of every month)
  **Week (1st, 2nd, 3rd, 4th, Last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date lands on a weekend or holiday, the payment will process on the following business day.**

### Payor Information

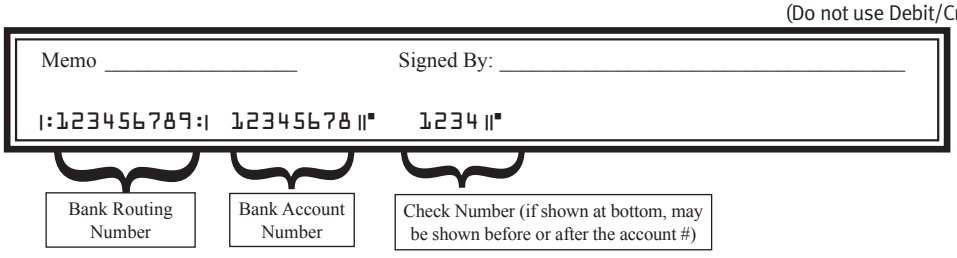
Name of payor as shown on bank account: _____

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 may be required)

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

### Payor 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)




### Payor Authorization

I authorize United of Omaha Life Insurance Company to initiate any initial or recurring preauthorized electronic transfers from my account. I understand the amounts may vary as premium shortages may result from a variety of reasons, including underwriting adjustments. 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 Life Insurance Company may require written confirmation within 15 days after my verbal notice.

Date _____ X _____

Mo./Day/Yr. Payor Authorized Signature as Shown on Account

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
Mutual of Omaha Insurance Company
Mutual of Omaha Affiliates

## 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**

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

***IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS***

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

## Disclosure for Term Life Insurance Policies

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

### Benefit Description

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated Terminal Illness benefit up to $1,000,000 or 80% of the policy's death benefit, whichever is less. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by 6% of the requested acceleration and a $100 charge.

### Effect of the Accelerated Terminal Illness benefit on the policy

When we pay the accelerated Terminal Illness benefit, the policy will continue with a reduced face amount and a reduced premium.

## Disclosure for Universal Life Insurance Policies

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

The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

### Benefit Description - Accelerated Benefit for Chronic Illness Rider

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated benefit.

Chronically Ill means that within the last 12 months a licensed health care practitioner has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

A requested acceleration may be of any amount you choose up to the maximum. There may be tax consequences of accepting an amount above the amount that would be tax qualified under the Internal Revenue Code. The sum of all requested chronic illness accelerations may not exceed the lesser of $500,000 or 80% of the specified amount as of the date of the first requested acceleration.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by a charge equal to 6% of the requested acceleration multiplied by the insured's life expectancy in years, a $100 charge, and the pro-rated amount of any outstanding loans.

### Benefit Description - Accelerated Death Benefit For Terminal Illness Rider

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated Terminal Illness benefit. A requested acceleration may be of any amount you choose up to a maximum. The terminal illness acceleration may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration, less any amounts accelerated under the Accelerated Benefit for Chronic Illness Rider.

A Terminal Illness is a medical condition that, with a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by 6% of the requested acceleration, a $100 charge, and the pro-rated amount of any outstanding loans.

### Effect of the Accelerated Benefit on the Policy

When we pay any accelerated benefit, the following will occur: (a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the benefit; and (b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.

## Acknowledgment

I acknowledge receipt of this disclosure form.

_____ _____

Applicant/Owner Signature Date

I have provided this disclosure form to the applicant.

_____ _____

Producer Signature Date

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# Accelerated Benefit for Chronic Illness Replacement Form

If applying for a policy with the Accelerated Benefit Rider for Chronic Illness, is it intended to replace any long-term care insurance or life insurance policy with an Accelerated Death Benefit Rider presently in force?.... ☐ **Yes** ☐ **No**

**If Yes, please complete the following "NOTICE TO APPLICANT" and sign below. If No, please skip the "NOTICE TO APPLICANT" section and sign below.**

## NOTICE TO APPLICANT

### NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG-TERM CARE INSURANCE OR LIFE INSURANCE INCLUDING ACCELERATED DEATH BENEFITS

According to information you have furnished, you intend to lapse or otherwise terminate existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by United of Omaha Life Insurance Company. Your new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and it is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitations on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site ( www.insurance.ca.gov) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

(1) Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax adviser.

(2) Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

**The above "Notice to Applicant" was delivered to me on:**

**Date:** _____ _____

Signature of Applicant/Owner

**COMPARISON TO YOUR CURRENT COVERAGE:** I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

____ Additional or different benefits

(please specify) _____.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ Other (please specify) _____.

**SIGNATURES**

_____ _____

Producer Signature Date

_____ _____

Applicant/Owner Signature Date

**Use with GULE, IULE, AccumUL Answers, Income Advantage, Life Protection Advantage, Professional Advantage**

**Company Copy**

# Temporary Life Insurance Agreement ("Agreement")

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

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

## Questions

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

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

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

## No Coverage

**There is NO temporary insurance coverage if:**

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

## Benefit

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

## Start Date

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

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

## End Date

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

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

## Signatures

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.

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

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

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

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

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

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date



**PLEASE SUBMIT TO HOME OFFICE**

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

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

To evaluate your Insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluids for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done.

## The HIV Antibody Test — Description and Purpose of the Test

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

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

## Meaning of Test Results

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

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

## Potential Uses and Disclosure of Test Results

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

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

## Limitations

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

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

## Counseling

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

## Notification of Test Result

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

Name of Physician _____

Address _____

## Consent

I have read and I understand this Notice and Consent form. I voluntarily consent to testing as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date _____

_____
Signature of Proposed Insured or Parent/Guardian

# IMPORTANT DOCUMENTS

## LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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

**Replacement Notices**
If replacing, you and the applicant must sign the customer copy of the replacement notice.

For those states that use **Form L6232_**:
This form must be completed if any existing coverage is listed on the application in the "Other Coverage Section," even if this is not a replacement.

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

***IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS***

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

## Disclosure for Term Life Insurance Policies

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### Benefit Description

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated Terminal Illness benefit up to $1,000,000 or 80% of the policy's death benefit, whichever is less. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by 6% of the requested acceleration and a $100 charge.

### Effect of the Accelerated Terminal Illness benefit on the policy

When we pay the accelerated Terminal Illness benefit, the policy will continue with a reduced face amount and a reduced premium.

## Disclosure for Universal Life Insurance Policies

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

The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

### Benefit Description - Accelerated Benefit for Chronic Illness Rider

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated benefit.

Chronically Ill means that within the last 12 months a licensed health care practitioner has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

A requested acceleration may be of any amount you choose up to the maximum. There may be tax consequences of accepting an amount above the amount that would be tax qualified under the Internal Revenue Code. The sum of all requested chronic illness accelerations may not exceed the lesser of $500,000 or 80% of the specified amount as of the date of the first requested acceleration.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by a charge equal to 6% of the requested acceleration multiplied by the insured's life expectancy in years, a $100 charge, and the pro-rated amount of any outstanding loans.

### Benefit Description - Accelerated Death Benefit For Terminal Illness Rider

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated Terminal Illness benefit. A requested acceleration may be of any amount you choose up to a maximum. The terminal illness acceleration may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration, less any amounts accelerated under the Accelerated Benefit for Chronic Illness Rider.

A Terminal Illness is a medical condition that, with a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by 6% of the requested acceleration, a $100 charge, and the pro-rated amount of any outstanding loans.

### Effect of the Accelerated Benefit on the Policy

When we pay any accelerated benefit, the following will occur: (a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the benefit; and (b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.

## Acknowledgment

I acknowledge receipt of this disclosure form.

_____ _____

Applicant/Owner Signature Date

I have provided this disclosure form to the applicant.

_____ _____

Producer Signature Date

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# Accelerated Benefit for Chronic Illness Replacement Form

If applying for a policy with the Accelerated Benefit Rider for Chronic Illness, is it intended to replace any long-term care insurance or life insurance policy with an Accelerated Death Benefit Rider presently in force?.... ☐ **Yes** ☐ **No**

**If Yes, please complete the following "NOTICE TO APPLICANT" and sign below. If No, please skip the "NOTICE TO APPLICANT" section and sign below.**

## NOTICE TO APPLICANT

### NOTICE TO APPLICANT REGARDING REPLACEMENT OF LONG-TERM CARE INSURANCE OR LIFE INSURANCE INCLUDING ACCELERATED DEATH BENEFITS

According to information you have furnished, you intend to lapse or otherwise terminate existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by United of Omaha Life Insurance Company. Your new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and it is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitations on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site ( www.insurance.ca.gov) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

(1) Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax adviser.

(2) Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

**The above "Notice to Applicant" was delivered to me on:**

**Date:** _____ _____

Signature of Applicant/Owner

**COMPARISON TO YOUR CURRENT COVERAGE:** I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

____ Additional or different benefits

(please specify) _____.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ Other (please specify) _____.

**SIGNATURES**

_____ _____

Producer Signature Date

_____ _____

Applicant/Owner Signature Date

**Use with GULE, IULE, AccumUL Answers, Income Advantage, Life Protection Advantage, Professional Advantage**

**Applicant Copy**

## The HIV Virus

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

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

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

## The AIDS Antibody Test

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

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

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

## Counseling Resources List

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

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

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

**SPANISH AIDS HOTLINE**
1-800-222-SIDA

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

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

**CENTRAL VALLEY AIDS TEAM**
Fresno
(209) 264-2436

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

**SACRAMENTO AIDS FOUNDATION**
Sacramento
(916) 448-2437

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

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

**SONOMA COUNTY AIDS FOUNDATION HOTLINE**
(707) 579-AIDS

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

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

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

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

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

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

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

**SHASTA COUNTY HELPLINE**
(916) 225-5252

MLU17089_1002

**GIVE THIS COPY TO THE APPLICANT**

# Temporary Life Insurance Agreement ("Agreement")

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

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

## Questions

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

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

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

## No Coverage

**There is NO temporary insurance coverage if:**

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

## Benefit

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

## Start Date

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

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

## End Date

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

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

## Signatures

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.

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

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

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

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

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

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date

## United of Omaha Life Insurance Company – 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.

## Investigative Consumer Reports Notice

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

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

Upon written request we will inform you whether an investigative consumer report was requested, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

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

## United of Omaha Life Insurance – Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate. In 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

## 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.

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

## A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, D.C. 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identify theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.
- In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

**States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights contact:**

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

**GIVE THIS COPY TO THE APPLICANT**

Mutual of Omaha

# Fit Test

Name: _____

Date: _____

**Complete with ALL Fully Underwritten Term and UL Applications**

## Requirements

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

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

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

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

## Lifestyle Characteristics

**Check all that apply**

Regular preventative medical care and compliant follow-up for treated impairments within past 12 months? ☐ **Yes**

No tobacco use for past 10 years? ☐ **Yes**

Income › $100,000 or net worth › $1,000,000? ☐ **Yes**

Preferred or better driving record? ☐ **Yes**

## Medical Characteristics

Great family history – no deaths from any disease prior to age 70? ☐ **Yes**

Cholesterol/HDL ratio under 5.0? ☐ **Yes**

A1c test ‹ 5.7? ☐ **Yes**

Serum albumin › 4.2 ages 61-75? ☐ **Yes**

Negative cardiac testing: GXT, non-imaged or imaged (stress echo, perfusion study), echocardiogram, EBCT or angiography (within the past 2 years)? ☐ **Yes**

GXT exercise performance over 10 METS (within the past 2 years)? ☐ **Yes**

Optimal blood pressure control-treated or untreated with average of 135/85 or better? ☐ **Yes**

Preferred or better build, ages 18-60. Standard plus or better build, ages 61-75? ☐ **Yes**

BNP ‹100 ages 61-75? ☐ **Yes**

Normal CBC ages 61-75? ☐ **Yes**

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

**Submit with Application**

**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 60 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.

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 60 months? . . . ❑ YES ❑ NO

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



**Applicant's/Owner's Copy**

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

# Acknowledgment/Illustration Certification Form - Universal Life Policies

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

## Producer/Agent

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

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

| | |
|---|---|
| _____<br>Print Name of Proposed Insured<br><br>Age: _____<br><br>Gender: ☐ Male ☐ Female<br><br>Underwriting or Rating Class: _____ | _____<br>Print Name of Other Proposed Insured<br><br>Age: _____<br><br>Gender: ☐ Male ☐ Female<br><br>Underwriting or Rating Class: _____ |

Type of Policy: _____ Initial Death Benefit $: _____

## Signatures

I make the certifications stated above:

_____ _____
Signature of Producer/Agent Date

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

_____ _____
Print Name of Applicant/Owner Date

_____ _____
Signature of Applicant/Owner Date

**PLEASE SUBMIT**

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# INDEXED UNIVERSAL LIFE PREMIUM ALLOCATION FORM

## (FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE)

| **Proposed Insured** | **Owner** (if other than Proposed Insured) |
|---|---|
| Name (First, Middle Initial, Last) | Name (First, Middle Initial, Last) |
| | Name (First, Middle Initial, Last) |

### Premium Allocation

Premium we credit to your account on an Allocation Date will be in the percentages you designate below. Premium we credit to your account on a date other than the Allocation Date will be allocated to the short-term holding account until the next Allocation Date. On a monthly deduction date, account values will be reduced by the pro-rata share of monthly expense charges, cost of insurance charges and any applicable monthly rider costs. The monthly deduction date is the issue date of your policy and each monthly anniversary of the issue date. The Allocation Date is the 10th of each calendar month.

_____% Fixed Account*

_____% One-Year 100% Participation*

_____% One-Year High Participation*

_____% One Year Uncapped*

_____% **Total (must equal 100%)**

Allocation percentage must be a whole number. Your premium allocations will remain in effect for all premium payments you make, until you change your premium allocations as described in the policy.

### Important Disclosures

This is a flexible premium adjustable life insurance policy with index-linked interest crediting options based on financial market indices. This is not an investment vehicle or variable life insurance policy. If you allocate premiums to the index account, the policy values will be affected by the change in the financial market indices. This life insurance policy does not directly participate in any equity, bond, mutual fund, commodities or other securities investments.

* Refer to the Index Interest Crediting Strategies section in the illustration for additional information on Index Interest Crediting Strategies.

### Signatures

I authorize United of Omaha Life Insurance Company to allocate premium as selected on this form.

_____ _____
Owner Signature Date

_____ _____
Owner Signature Date

**COMPANY COPY**