CALIFORNIA – Application for Life Insurance

Simplified issue Products – *One Base Policy per Application*

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

✍ *Checklist for Submitting a Complete Application*

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

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

❑ Universal Life Products:
- Indexed Universal Life Express

❑ Universal Life Express Riders:
- Accidental Death Benefit Rider
- Guaranteed Insurability Rider
- Disability Waiver of Policy Charges Rider
- Disability Continuation of Planned Premium Rider
- Dependent Children's Rider

❑ Term Product:
- Term Life Express

❑ Term Life Riders:
- Accidental Death Benefit Rider
- Dependent Children's Rider
- Disability Income Rider
- Disability Waiver of Premium Rider

Application Submission Guidelines

❑ Attach a cover letter or additional information as needed.

❑ Always submit the Producer Statement and Producer Report page.

❑ Always leave all applicable forms and the Life Insurance Buyer's Guide with the client.

❑ 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.

Important Forms

❑ Replacement Notice – if applicable, the client must sign and retain a copy for their records.

❑ Payment Authorization – Complete this form if applicable.

❑ Conditional Receipt – Complete ONLY if you accepted a check or electronic transaction authorization at time of application for the initial premium. **DO NOT** complete the Conditional Receipt if initial payment won't be collected until issue.

❑ Accelerated Benefit Rider Disclosure – The client must sign the Accelerated Benefit Rider Disclosure Form.

❑ Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor – Complete this form if applicable. The client must sign and retain a copy for their records.

Supplemental Applications, Forms, and Buyer's Guide:

- ***Child(s) Rider Supplemental Application:*** Required for the Children's Rider.
- ***Disability Supplemental Application:*** Required for the following riders - Disability Waiver of Policy Charges, Disability Continuation of Planned Premium, Disability Income or Disability Waiver of Premium.
- ***Indexed Universal Life Premium Allocation form:*** Required when selecting Indexed Universal Life Express Without Easy Solve on the application.
- ***Illustration:*** Required with signature for Indexed Universal Life Express applications.
- ***Acknowledgment/Illustration Certification form:*** Required when no illustration was used at point of sale, a hard copy of the illustration was not furnished or the policy applied for is other than shown in the illustration.
- ***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.

Mutual of Omaha

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

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

INDIVIDUAL LIFE INSURANCE APPLICATION

Proposed Insured

Name (First, Middle Initial, Last)	Social Security No.	Sex	Height	Weight	Annual Income

Home Address (Street, City, State, ZIP)	State of Birth	Date of Birth

Best Time to Call	Phone Number	E-mail

Driver's License No.	Driver's License State	Occupation/Duties	Employer

U.S. Citizen?.... ☐ **Yes** ☐ **No** (If "No," complete the Foreign National and Foreign Travel questionnaire)

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

Plan Information

Term Life:

☐ 30-Year Level Term Life with 30 Year Guarantee
☐ 20-Year Level Term Life with 20 Year Guarantee
☐ 15-Year Level Term Life with 15 Year Guarantee
☐ 10-Year Level Term Life with 10 Year Guarantee

Term Life Express Amount of Insurance Applied for

$_____

Return of Premium..... ☐ **Yes**
(only available for 30-Year Guarantee)

Term Riders: (Complete Supplemental Applications if applying for a Disability Rider or the Children's Rider)

☐ Disability Income Rider (not available with Return of Premium): ☐ 18 months ☐ 30 months
Disability Income Rider Monthly Benefit $_____
☐ Disability Waiver of Premium
☐ Dependent Children's Rider Benefit Amount of Insurance Applied for: ☐ $5,000 ☐ $10,000
☐ Accidental Death Benefit Rider Amount of Insurance Applied for $ _____

Permanent Life:

☐ Indexed Universal Life Express Amount of Insurance Applied for $_____

Choose one: ☐ **With Easy Solve**
Level Death Benefit and 100% Allocated to the '1-Year 100% Participation Strategy'
Do NOT submit the IUL Allocation Form.

☐ **Without Easy Solve**
☐ Option 1 Level Death Benefit
☐ Option 2 Specified Amount Plus Accumulation Value
The IUL Allocation Form MUST be submitted.

Permanent Life Riders: (Complete Supplemental Applications if applying for a Disability Rider or the Children's Rider)

☐ Disability Waiver of Policy Charges Rider ☐ Disability Continuation of Planned Premium Rider Amount $_____
☐ Dependent Children's Rider Benefit Amount of Insurance Applied for: ☐ $5,000 ☐ $10,000
☐ Accidental Death Benefit Rider Amount of Insurance Applied for $ _____

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

Modal Premium $_____ Collected Premium $_____

Owner (Complete Policyowner Information if Proposed Insured is not the Policyowner)

Name of Policyowner (First, Middle Initial, Last)	Relationship to Proposed Insured	Date of Birth	Phone No.

Policyowner Address (Street, City, State, ZIP)	Social Security No./Tax ID	Citizenship Country

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Beneficiary

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

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

Other Coverage Information

1. List below all life insurance policies and/or annuity contracts on any person proposed for insurance that are now pending or are now in force (including any that have been assigned or sold). If none, check the following box.. ☐ **None**

2. Has the Proposed Insured had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? ..... ☐ **Yes** ☐ **No**

The Producer shall comply with any additional state and/or company replacement requirements.

Company	Face Amount	ADB Amount	To Be Replaced or Converted?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

3. **In the past 10 years,** has the Proposed Insured been declined for life insurance coverage? ..... ☐ **Yes** ☐ **No**

4. Has the Proposed Insured been offered cash or any other consideration for obtaining this policy? ..... ☐ **Yes** ☐ **No**

5. Are you planning to enter into a finance arrangement to pay any premium payments due under this policy?..... ☐ **Yes** ☐ **No**

6. 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 3, 4, 5 or 6 provide information in Comments section.

Comments

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

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UNDERWRITING

If the Proposed Insured answers "Yes" to questions 1 through 7 in this section, that person is not eligible for coverage under this application.	Proposed Insured
1. Has the Proposed Insured ever been diagnosed as having Acquired Immune Dificiency Syndrome (AIDS), AIDS Related Complex (ARC), or been treated for AIDS or ARC by a physician or health care provider?	☐ **Yes** ☐ **No**
2. Has the Proposed Insured **ever** (i) been diagnosed with, or (ii) received care or treatment for, or (iii) been advised by a member of the medical profession to seek treatment for, or (iv) consulted with a health care provider regarding:	
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease with Repair or Replacement, Cardiomyopathy, Congestive Heart Failure, Congenital Heart Disease, Stroke, Transient Ischemic Attack (TIA)/mini-stroke, abnormal heart rhythm, or Cerebral, Aortic or Thoracic Aneurysm?	☐ **Yes** ☐ **No**
(b) Chronic Lung Disease (except mild Asthma), including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis?	☐ **Yes** ☐ **No**
(c) Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Sickle Cell Anemia, Lou Gehrig's Disease (ALS), Muscular Dystrophy, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down's Syndrome, Autism, mental incapacity, or any other disease of the central nervous system?	☐ **Yes** ☐ **No**
(d) Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C?	☐ **Yes** ☐ **No**
(e) Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell or squamous cell skin cancer)?	☐ **Yes** ☐ **No**
(f) Systemic Lupus or Scleroderma?	☐ **Yes** ☐ **No**
(g) an organ transplant?	☐ **Yes** ☐ **No**
3. Has the Proposed Insured **currently or within the past 12 months**:	
(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**
(b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services or is the Proposed Insured currently confined to any hospital or other medical facility?	☐ **Yes** ☐ **No**
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	☐ **Yes** ☐ **No**
4. In the past 12 months, has the Proposed Insured:	
(a) been advised by a member of the medical profession to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS , treatment, or other procedure which has not been done?	☐ **Yes** ☐ **No**
(b) consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds (other than due to diet or exercise), fatigue or unexplained gastrointestinal bleeding?	☐ **Yes** ☐ **No**
5. In the next 2 years, will the Proposed Insured engage in any motor sports racing, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing?	☐ **Yes** ☐ **No**
6. In the past 10 years, has the Proposed Insured:	
(a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a member of the medical profession?	☐ **Yes** ☐ **No**
(b) used or been convicted of possession of unlawful drugs or used prescription drugs other than as prescribed in any form?	☐ **Yes** ☐ **No**
(c) been convicted of or currently awaiting trial for a felony?	☐ **Yes** ☐ **No**
(d) been hospitalized for high blood pressure or any mental or nervous disorder?	☐ **Yes** ☐ **No**
7. In the past 5 years, has the Proposed Insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had four or more moving violations?	☐ **Yes** ☐ **No**

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Underwriting Continued

	Proposed Insured
8. Has the Proposed Insured ever (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Diabetes?	☐ **Yes** ☐ **No**
(b) Diabetes before age 50 other than Gestational Diabetes?	☐ **Yes** ☐ **No**
(c) Diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)?	☐ **Yes** ☐ **No**
9. In the past 12 months, has the Proposed Insured applied for or received disability, hospital or medical benefits from any insurance company, government, employer, or other source (other than for maternity, fractures, spinal or back disorders or hip or knee replacement)?	☐ **Yes** ☐ **No**
10. In the past 5 years, has the Proposed Insured consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition (other than for routine physical checkups, eye, employment or FAA examinations)?	☐ **Yes** ☐ **No**

If answered "Yes" to questions 8-10, please list details below. If more space is needed, use the Comments section in Part 1.

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

~~**11.** If the Proposed Insured is age 61 or older with a face amount greater than $250,000, provide the name and address of personal physician.~~

Authorization and Agreement

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

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

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

_____
Signature of Proposed Insured Age 15 and Over

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

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

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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** _____

_____

_____

6. **(a)** Are you related to the Proposed Insured or Owner? ☐ **Yes** ☐ **No** **If "Yes," state relationship** _____

_____

(b) How long have you known the Proposed Insured? _____

(c) How long have you known the Proposed Owner? _____

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

Address	From	To

_____ _____ _____
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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Producer's Report

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

1. Proposed Primary
Insured Full Name _____
First Name Initial Last Name

2. Please Note: A recent mortgage is not required for issuance of this policy.

Has the Proposed Insured purchased a home or refinanced a home within the last 2 years? ..... ☐ **Yes** ☐ **No**
If "Yes," then complete the remainder of Question 2

Approximate Mortgage Loan Amount $ _____

Mortgage Loan Financial Institution Name _____

3. 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**

_____

_____

_____

_____

_____

_____

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

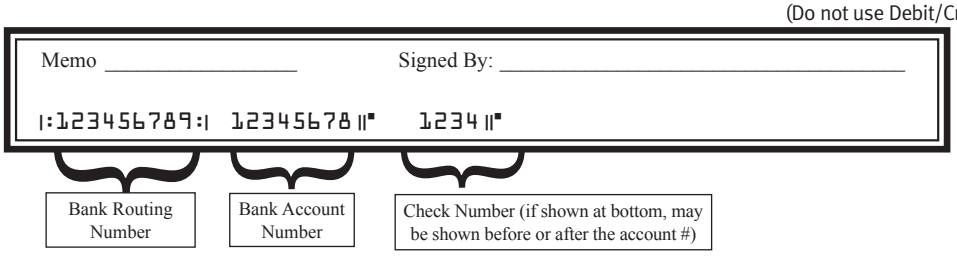
Name of payor as shown on bank account: _____

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 Insurance Company
United of Omaha Life Insurance Company

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

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

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

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

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

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

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

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

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

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

M28704

Company's Copy

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 or cost of insurance charge for the rider.

Benefit Description

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

Effect of the Accelerated Death Benefit on the Policy

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

Disclosure for Universal Life Insurance Policies

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated 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

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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 IULE, AccumUL Answers, Income Advantage, Life Protection Advantage, Professional Advantage

Company Copy

Conditional Receipt ("Receipt")

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

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

Date of Receipt:_____

Benefit

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) $100,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed $100,000.

Conditions

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

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

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

End Date

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

1 60 days from the date of this Receipt; or
2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 The date the Applicant/Owner withdraws the application for insurance.

Signatures

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

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

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

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

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

I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date

Mutual of Omaha

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

Third Party Notice Request Form

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

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

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

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

Section 1

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

Policyowner/Certificateholder: _____

Policy Number: _____ Date: _____

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

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

Third Party Phone: (_____) _____
(Area Code) (Number)

Signature of Policyowner/Certificateholder

_____

Date _____

Section 2

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

Signature of Policyowner/Certificateholder

_____

Date _____

Direct all correspondence to: United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

L8524

CLIENT FORMS

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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

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 or cost of insurance charge for the rider.

Benefit Description

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

Effect of the Accelerated Death Benefit on the Policy

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

Disclosure for Universal Life Insurance Policies

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated 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 IULE, AccumUL Answers, Income Advantage, Life Protection Advantage, Professional Advantage

Applicant Copy

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

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

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

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

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

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

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

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

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

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

M28704

Conditional Receipt ("Receipt")

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

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

Date of Receipt:_____

Benefit

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) $100,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed $100,000.

Conditions

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

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

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

End Date

This Receipt and any coverage provided hereunder will **END** on the earliest of the following dates:
1 60 days from the date of this Receipt; or
2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 The date the Applicant/Owner withdraws the application for insurance.

Signatures

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

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

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

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

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

I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date

United of Omaha Life Insurance Company - MIB Group, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. United of Omaha Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information is: 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 may be obtained on its website at www.mib.com.

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. I the event of an adverse underwriting decision, our Company will provide in writing 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.

Applicant's/Owner's Copy L8580_CA

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

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

Life Application Submission Form

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

Comments: _____

_____

_____

Name of Insured

Name of Agent	Production Number	Phone Number	Email Address

Next Highest Upline	Production Number	Phone Number	Email Address

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

_____

_____

_____

_____

_____

_____