

# Life Insurance Application



---

**Application To:**

United of Omaha Life Insurance Company

- ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476

---

**For**

- |   |   |
|---|---|
| <input type="checkbox"/> Life Insurance | <input type="checkbox"/> Flexible Premium Variable Universal Life Insurance |
| <input type="checkbox"/> Adult Life     | <input type="checkbox"/> Additional Insured Rider (AIR)                     |
| <input type="checkbox"/> Juvenile Life  | <input type="checkbox"/> Specified Amount Increase                          |

---

**To The Agent/Broker:**

- Tear off the Notice of Exchange of Information, Summary of Rights Under the Fair Credit Reporting Act and give it to the Applicant.
- Have Authorization To Release Information on reverse side of this page signed and dated.
- Assure that all applicable questions in Part I and Part II are answered in clear printed fashion.
- Complete Nonmedical Supplement in **all** cases.
- Be sure the application is signed by the Proposed Insured(s) and the Applicant if other than Proposed Insured(s).
- Any changes should be initialed by the Proposed Insured(s) and, if applicable, the Applicant.
- Use age last birthday.
- Always provide the attached Temporary Life Insurance Agreement and Receipt when you accept a premium.

**Premium Acceptance Guidelines:**

Premium should only be accepted if:

- (a) Questions 1, 2, 3 and 4 on the Temporary Life Insurance Agreement and Receipt form are answered "No."
- (b) The Temporary Life Insurance Agreement and Receipt form is signed, dated and witnessed by all parties indicated on the form on the day the application is taken.
- (c) A **full modal premium** is collected at the time of application unless the Bank Service Plan (BSP) is used, in which case **two** BSP premiums should be collected.
- (d) The total amount of insurance applied for does not exceed \$500,000.

# Part I of Application for Life Insurance to United of Omaha Life Insurance Company

## A. General Questions

1 Proposed Insured's Name: \_\_\_\_\_ Former Name (if applicable): \_\_\_\_\_

2 Home Phone Number: ( ) \_\_\_\_\_ Best Time to Call: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

3 Legal Residence Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP

4 Mailing Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP

5 Mail Premium Notices to:  Residence  Owner  Business  
Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP

6 Sex:  M  F Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace (state): \_\_\_\_\_

7 Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

8 Are you a U.S. citizen?  Yes  No If "No," date of arrival in U.S. \_\_\_\_\_  
Do you have an alien registration receipt "Permanent Visa"?  Yes  No If "Yes," Permanent Visa No.: \_\_\_\_\_

9 Occupation: \_\_\_\_\_ Duties: \_\_\_\_\_  
Businessowner?  Yes  No Retired Military?  Yes  No Active Duty?  Yes  No  
If "Yes," are you on flying status or receiving hazardous duty pay?  Yes  No  
If "Yes," explain type of duty or type of aircraft: \_\_\_\_\_

10 Name of your firm or employer: \_\_\_\_\_

11 Business Phone Number: ( ) \_\_\_\_\_ Best Time to Call: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

12 Local Business Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP

13 Do you use tobacco in any form?  Yes. What form? \_\_\_\_\_ No. per day: \_\_\_\_\_  
 No.  Never Used.  Stopped on \_\_\_\_/\_\_\_\_/\_\_\_\_

14 Applicant/Owner Name (if different from Proposed Insured or if Proposed Insured is under Age 15):  
Address: \_\_\_\_\_  
Street No., Apt. No. City, State ZIP

Relationship to Proposed Insured: \_\_\_\_\_ Social Security No. (or Taxpayer ID No.): \_\_\_\_\_

15 Complete only if Spouse/Children (must be full time student if over age 19) are Proposed for Insurance:

First Name, Middle Initial and Last Name	SSN No.	Relationship to Proposed Insured	Birth Date	Age	Sex	Ht.	Wt.

16 Spouse's Occupation: \_\_\_\_\_ Birthplace (state): \_\_\_\_\_  
Income: \$ \_\_\_\_\_ If self-employed, income after expenses and before taxes: \$ \_\_\_\_\_  
Driver's License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

17 Is spouse a U.S. citizen?  Yes  No If "No," date of arrival in the U.S. \_\_\_\_\_  
Does spouse have an alien registration receipt "Permanent Visa"?  Yes  No  
If "Yes," Permanent Visa Number: \_\_\_\_\_

18 Does spouse use tobacco in any form?  Yes. What form? \_\_\_\_\_ No. per day: \_\_\_\_\_  
 No.  Never Used.  Stopped on \_\_\_\_/\_\_\_\_/\_\_\_\_

19 Do all family members proposed for insurance live with the Proposed Insured?  Yes  No If "No," explain and give name and phone number where family member can be contacted \_\_\_\_\_

20 Plan Information

- a. Plan of Insurance: \_\_\_\_\_  
Amount: \_\_\_\_\_
- b.  Addition to Existing Policy No.: \_\_\_\_\_  
Amount: \_\_\_\_\_
- c. Death Benefit Option:  
 Option 1: Accumulation Value included in Specified Amount  
 Option 2: Accumulation Value in addition to Specified Amount
- d. I elect the Automatic Premium Deduction Option.  
(Not available with all plans)  Yes  No
- e. Riders:  
(Please Note: Not all riders are available with all plans)
- Waiver of Premium or Disability \_\_\_\_\_
  - Accidental Death Benefit \_\_\_\_\_
  - Guaranteed Issue Benefit \_\_\_\_\_
  - Children's Rider \_\_\_\_\_
  - Spouse (indicate type of coverage) \_\_\_\_\_
  - Additional Insured Rider (Self, Spouse) \_\_\_\_\_
  - Other Insured Rider \_\_\_\_\_
  - Other \_\_\_\_\_

	Premium	
	\$ _____	THIS BOX FOR ADMINISTRATIVE PURPOSES ONLY
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
	\$ _____	
Total Premium	\$ _____	

f. Amount Collected (Cash with App):	Explanation of Amount Collected	Mode	Total Premium
\$ _____			\$ _____

21 List all Life Insurance now in force or pending on any Proposed Insured(s). If none, write "None." Have you had or do you intend to have any life insurance policy replaced, converted, reduced, reissued, subjected to borrowing, or otherwise discontinued because of this application? If "Yes," so indicate below.

Company	Policy Number	Face Amount	Pending	ADB Amount	To Be Replaced, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No	1035 Exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

22 Life Insurance Beneficiary (Give full names and relationship).  
**Note:** Unless you specify otherwise, payments will be shared equally by all primary beneficiaries who survive the Insured or, if none, by all contingent beneficiaries who survive the Insured. The right to change the beneficiary is reserved unless otherwise stated.

- See Attached Beneficiary Designation
- Primary Beneficiary(ies)
- Name \_\_\_\_\_ Relationship \_\_\_\_\_ SSN No. \_\_\_\_\_
- Name \_\_\_\_\_ Relationship \_\_\_\_\_ SSN No. \_\_\_\_\_
- Contingent Beneficiary(ies):
- Name \_\_\_\_\_ Relationship \_\_\_\_\_ SSN No. \_\_\_\_\_
- Name \_\_\_\_\_ Relationship \_\_\_\_\_ SSN No. \_\_\_\_\_

23 Complete only for PRD or Association Group or Franchise Coverage:

Full Name of Group/Organization \_\_\_\_\_ Date Joined \_\_\_\_\_

Group/Membership No.: \_\_\_\_\_ Relationship to above:  Shareholding Member

Dues-paying Member  Other \_\_\_\_\_

# Part II of Application for Life Insurance – Nonmedical Supplement

Please Print. All Questions Relate to Anyone Proposed for Insurance.

Wisconsin Residents: AIDS (HIV) test results received at an anonymous counseling and testing site need not be disclosed.

1 Name, address and telephone number of personal physician of each person proposed for insurance:

\_\_\_\_\_

\_\_\_\_\_

(a) Date last seen: \_\_\_\_\_

(b) State reason, findings and treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2 Name and address of physician most recently consulted by each person proposed for insurance: \_\_\_\_\_

(a) Date: \_\_\_\_\_ (b) State reason, findings and treatment \_\_\_\_\_

3 Have you, or any person proposed for insurance, ever been told that you had, or have you consulted or been treated by a physician or licensed practitioner for any of the following:

YES NO

- (a) Any disease or abnormal condition of the heart, circulatory system or blood vessels, high blood pressure, rapid pulse, rheumatic fever, murmur, coronary artery disease, chest pain, angina or stroke? . . . . .
- (b) Any disease of the lungs or respiratory system, including tuberculosis, asthma, bronchitis, emphysema or shortness of breath? . . . . .
- (c) Any digestive system disease, including stomach or duodenal ulcer, indigestion, stomach pain, liver or gallbladder disease, colon or rectal disorder? . . . . .
- (d) Any genitourinary system disease including albumin, blood or sugar in urine, kidney infection or stones, tumor or disease of the prostate, testis, breasts, uterus or ovaries? . . . . .
- (e) Any nervous, brain or mental disorder, convulsions, dizziness, headaches, epilepsy, nervous breakdown or paralysis? . . . . .
- (f) Any bone or joint disorder, arthritis or rheumatism, bodily deformity, back or spinal disorder? . . . . .
- (g) Any disease or impairment of vision or hearing? . . . . .
- (h) Gout, diabetes, thyroid or other glandular disorder, cancer, tumor or blood disorder other than AIDS or AIDS Related Complex (ARC). . . . .

4 Have you, or any person proposed for insurance, ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), caused by the HIV infection, or been treated for AIDS or ARC by a physician or licensed practitioner? . . . . .

- 5 During the past 10 years, have you, or any person proposed for insurance:
- (a) had any illness, injury, surgery, hospitalization, medical examination or care not listed above? . . . . .
  - (b) had or received treatment for any unexplained fever, fatigue or chronic cough? . . . . .
  - (c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test? . . . . .
  - (d) been advised by a physician to have a surgical operation? . . . . .
  - (e) been advised by a physician to limit your use of alcohol? . . . . .

6 Are you, or any person proposed for insurance, now taking any medication prescribed by a physician? . . . . .

- 7 During the last 10 years, have you, or any person proposed for insurance:
- (a) used alcohol or other drugs to a degree that required treatment or advice from a physician or other licensed practitioner? . . . . .
  - If "Yes," has use been discontinued? . . . . .
  - (b) been or are currently a member of Alcoholics Anonymous or Narcotics Anonymous? . . . . .

8 If pregnant, enter approximate delivery date: \_\_\_\_\_

9 Height: \_\_\_\_\_ ft. \_\_\_\_\_ ins. Weight: \_\_\_\_\_ lbs.  
Weight change during last 12 months: Lbs. Gained: \_\_\_\_\_ Lost: \_\_\_\_\_





# Agent's/Broker's Report

(Must be completed by the agent/broker who obtained the application on the Proposed Insured named below.)

1 Is Proposed Insured self-supporting?  Yes  No If "No," provide the following information about the person on whom Proposed Insured is dependent:

Full Name \_\_\_\_\_ Address \_\_\_\_\_ Birth Date \_\_\_\_\_

Amount of insurance carried with all companies \$ \_\_\_\_\_ If none, state why \_\_\_\_\_

2 If Proposed Insured used different name in past, give previous full name \_\_\_\_\_

3 (a) Are you related to Proposed Insured or Owner?  
 Yes  No  
 If "Yes," state relationship \_\_\_\_\_

(b) How long have you known Proposed Insured? \_\_\_\_\_

(c) How long have you known Proposed Owner? \_\_\_\_\_

4 When did you last see Proposed Insured? \_\_\_\_\_

5 Did you ask Proposed Insured or Owner every question as printed (if "No," explain below)?  
 Yes  No

6 Do you have any information not presented in this application which might in any way affect this risk (if "Yes," explain below)?  Yes  No

7 Proposed Insured's Annual Income \$ \_\_\_\_\_  
 Exact  Estimated

8 What is the purpose of this insurance? Give details including financial information (for amounts of \$500,000 or more, financial statements may be requested)  
 \_\_\_\_\_  
 \_\_\_\_\_

9 (a) Is a medical exam to be completed?  Yes  No

(b) Name of examiner or paramedical facility \_\_\_\_\_  
 \_\_\_\_\_

10 Previous residence and business addresses of Proposed Insured for past five years.

Address	From	To

11 Is another policy requested based on this application?  
 Additional policy Plan \_\_\_\_\_  
 Alternate policy Amount \$ \_\_\_\_\_  
 Owner (if different) \_\_\_\_\_  
 Beneficiary (if different) \_\_\_\_\_

12 Is Proposed Insured applying for insurance with any other company (if "Yes," give details)?  Yes  No  
 \_\_\_\_\_  
 \_\_\_\_\_

13 To the best of your knowledge will this policy replace any existing life insurance or annuity (if "Yes," give details and fulfill all state requirements)?  Yes  No  
 \_\_\_\_\_  
 \_\_\_\_\_

**Details:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Agent(s)/Broker(s) to Receive Commission and Volume Credit for This Application**

Agent's/Broker's Full Name	Agent's/Broker's Production No.	% Credit
1 _____		
2 _____		

I hereby certify that I have truly and accurately recorded the information furnished by the Owner and/or Proposed Insured.

\_\_\_\_\_  
 Date Signature of Agent(s)/Broker(s) Agent(s)/Broker(s) Name (Please Print)

\_\_\_\_\_  
 Name of Division Office/Wholesaler Name of Assistant Wholesaler (Brokerage Only)

**Meanings of Terms**

**“Medical Persons and Entities” means:** all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

**“Personal Information” means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

**“Psychotherapy Notes” means:** notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Disclose**

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to United of Omaha Life Insurance Company.

**Purposes**

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

**Potential For Redisclosure**

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 then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations. We have contracts with persons and entities which act on our behalf which require them to maintain the confidentiality of the Personal Information.

**Failure to Sign**

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

**Inspection and Copying**

I have the right to inspect or copy Personal Information disclosed under this authorization.



**Authorization To Disclose Personal Information (continued)**

**Expiration and Revocation**

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:

ATTN: Individual Underwriting  
Mutual of Omaha  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that any of the Specified Companies has taken action in reliance on the authorization or the law allows any of the Specified Companies to contest the issuance of the policy or a claim under the policy.

**Copy**

I understand that I, or my authorized representative, will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

**Names and Signatures**

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

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
If children are to be insured, their printed names

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse's Printed Name (If Proposed Insured)

\_\_\_\_\_  
Signature of Spouse (If Proposed Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

# Bank Service Plan Request Form

## Complete the following information:

Insured's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Coverage ID Number(s):

\_\_\_\_\_

\_\_\_\_\_

## Specify Preferred Date of Withdrawals

Please indicate when you prefer the monthly premiums to be withdrawn from your checking account:

Withdraw on the \_\_\_\_\_ (1st through 28th) of the month

## Bank Service Plan Authorization

As a convenience to me, I authorize Mutual of Omaha Insurance Company and/or its affiliated companies\* to withdraw funds from my account.

I also authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to the appropriate company(ies) below. Your rights with each such charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Date \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature as Shown on Account

\_\_\_\_\_  
Joint Account or Other Authorized Signature

\*MUTUAL of OMAHA INSURANCE COMPANY UNITED of OMAHA LIFE INSURANCE COMPANY  
UNITED WORLD LIFE INSURANCE COMPANY Mutual of Omaha Plaza Omaha, Nebraska 68175

All checks must be made payable to United of Omaha. Do not make checks payable to the agent/producer or leave the payee blank. We will not accept cash premiums.

# Temporary Life Insurance Agreement and Receipt (“Agreement”)

United of Omaha Life Insurance Company (“United,” “We,” “Our,” “Us”), Mutual of Omaha Plaza, Omaha, NE 68175

The following questions must be answered either “Yes” or “No.”

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 licensed medical professional?.....
- 3. Has any person proposed for insurance been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC)? .....
- 4. Is any Proposed Insured under 15 days old or over 70 years of age?.....

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**If any of the above questions are answered “Yes” or not answered, no Agent/Broker of United is authorized to accept money with the application and no coverage will take effect under this Agreement.**

In consideration of the application and payment of \$ \_\_\_\_\_ by the Applicant, receipt of which is hereby acknowledged, United agrees to provide temporary life insurance for the Proposed Insured(s) effective on the date of the application, for a limited period of time, subject to the following conditions and limitations.

- A. If the answer to any of the above questions is “No” and the answer is incorrect or misleading, or if any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.
- B. Temporary life insurance under this Agreement will automatically terminate on the earliest of the following dates:
  - (1) 90 days from the date of this Agreement, except in Connecticut; or
  - (2) the date that insurance takes effect under the policy applied for; or
  - (3) the date of the letter offering to the Applicant a policy, other than applied for; or
  - (4) the date a policy, other than as applied for, is offered by an Agent/Broker to the Applicant; or
  - (5) the date the premium refund is mailed; or
  - (6) the date any check or draft submitted as payment is not honored by the bank on which it is drawn; or
  - (7) the date United mails notice of termination of coverage.
- C. If the policy applied for is either (a) pursuant to a conversion privilege in (an) existing United life policy(ies), or (b) to replace (an) existing United life policy(ies) with another United life policy, then in the event of the death of the Proposed Insured before the termination of this Agreement, United will pay only the greater of:
  - (1) the benefits due under the terms of the existing policy(ies) which is/are being converted or replaced, or
  - (2) the benefits due under the terms of the policy for which application is being made (subject to the further limitation on the maximum amount of benefits payable under this Agreement which is set forth below); and Applicant acknowledges and agrees that benefits shall not be payable under both.
- D. The temporary life insurance provided by this Agreement is subject to the provisions of the policy form applied for; however, no benefits will be paid for:
  - (1) disability; or
  - (2) death from suicide while sane or insane; or
  - (3) the same loss under both this Agreement and any life policy issued from the application.

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 the application is rejected by United, the amount paid with the application will be refunded to the Applicant regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Agent/Broker.

**If any Proposed Insured dies prior to the termination of this Agreement, United will pay the beneficiary the face amount applied for (unless otherwise required by C above), not to exceed \$500,000.**

I have read and received a copy of this Agreement and understand and agree to all of its terms. I verify the above answers are true.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Signature of Applicant (if other than Proposed Insured)

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Signature of Spouse (if a Proposed Insured)

\_\_\_\_\_  
Printed Name of Spouse

\_\_\_\_\_  
Signature of Agent(s)/Broker(s)

\_\_\_\_\_  
Printed Name of Agent(s)/Broker(s)

**SUBMIT THIS COPY TO THE COMPANY**

All checks must be made payable to United of Omaha. Do not make checks payable to the agent/producer or leave the payee blank. We will not accept cash premiums.

## Temporary Life Insurance Agreement and Receipt (“Agreement”)

United of Omaha Life Insurance Company (“United,” “We,” “Our,” “Us”), Mutual of Omaha Plaza, Omaha, NE 68175

The following questions must be answered either “Yes” or “No.”

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 licensed medical professional?.....
3. Has any person proposed for insurance been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC)? .....   
**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**
4. Is any Proposed Insured under 15 days old or over 70 years of age?.....

**If any of the above questions are answered “Yes” or not answered, no Agent/Broker of United is authorized to accept money with the application and no coverage will take effect under this Agreement.**

In consideration of the application and payment of \$ \_\_\_\_\_ by the Applicant, receipt of which is hereby acknowledged, United agrees to provide temporary life insurance for the Proposed Insured(s) effective on the date of the application, for a limited period of time, subject to the following conditions and limitations.

- A. If the answer to any of the above questions is “No” and the answer is incorrect or misleading, or if any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.
- B. Temporary life insurance under this Agreement will automatically terminate on the earliest of the following dates:
  - (1) 90 days from the date of this Agreement, except in Connecticut; or
  - (2) the date that insurance takes effect under the policy applied for; or
  - (3) the date of the letter offering to the Applicant a policy, other than applied for; or
  - (4) the date a policy, other than as applied for, is offered by an Agent/Broker to the Applicant; or
  - (5) the date the premium refund is mailed; or
  - (6) the date any check or draft submitted as payment is not honored by the bank on which it is drawn; or
  - (7) the date United mails notice of termination of coverage.
- C. If the policy applied for is either (a) pursuant to a conversion privilege in (an) existing United life policy(ies), or (b) to replace (an) existing United life policy(ies) with another United life policy, then in the event of the death of the Proposed Insured before the termination of this Agreement, United will pay only the greater of:
  - (1) the benefits due under the terms of the existing policy(ies) which is/are being converted or replaced, or
  - (2) the benefits due under the terms of the policy for which application is being made (subject to the further limitation on the maximum amount of benefits payable under this Agreement which is set forth below); and Applicant acknowledges and agrees that benefits shall not be payable under both.
- D. The temporary life insurance provided by this Agreement is subject to the provisions of the policy form applied for; however, no benefits will be paid for:
  - (1) disability; or
  - (2) death from suicide while sane or insane; or
  - (3) the same loss under both this Agreement and any life policy issued from the application.

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 the application is rejected by United, the amount paid with the application will be refunded to the Applicant regardless of whether a claim has been filed or benefits have been paid under this Agreement.

No change may be made to the terms and conditions of this Agreement by anyone, including the Agent/Broker.

**If any Proposed Insured dies prior to the termination of this Agreement, United will pay the beneficiary the face amount applied for (unless otherwise required by C above), not to exceed \$500,000.**

I have read and received a copy of this Agreement and understand and agree to all of its terms. I verify the above answers are true.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Signature of Applicant (if other than Proposed Insured)

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Signature of Spouse (if a Proposed Insured)

\_\_\_\_\_  
Printed Name of Spouse

\_\_\_\_\_  
Signature of Agent(s)/Broker(s)

\_\_\_\_\_  
Printed Name of Agent(s)/Broker(s)

**SUBMIT THIS COPY TO THE APPLICANT**

**Authorization To Receive And Disclose Information**

**Meanings of Terms**

**“MIB Group, Inc. (MIB)” means:** a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

**“Personal Information” means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Receive and Disclose**

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the 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.

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

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:

Attn: Individual Underwriting  
Mutual of Omaha  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

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

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (If Proposed Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

**Instructions to Agent/Broker: Give this Notice to the Applicant before filling out the application.**

## **Notice of Exchange of Information**

### **Medical Information Bureau, Inc. (MIB)**

The information regarding your insurability will be treated as confidential.

However, the Company or its reinsurers may make a brief report to the Medical Information Bureau, a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply for life or health insurance to another company which is also a member of the Bureau or if a claim for benefits is submitted to such a company, the Bureau will, upon request, supply the information in its file to that company.

Florida residents: However, no information obtained from the Medical Information Bureau pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of the policy, except upon written consent to be medically tested for HIV or AIDS and the results of such testing proved positive.

Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, phone (617) 426-3660.

The Company or its reinsurers may also release information in its file, including information given in your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

## **Fair Credit Reporting Act Disclosure Statement**

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

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

Upon written request, we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights Under Section 606 (a) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address:

**Attention:** Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, Nebraska 68175

## **Notice of Information Practices**

In the course of properly underwriting and administering your insurance coverage, United of Omaha Life Insurance Company will rely heavily on information provided by you. The Company may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, consumer reporting agencies, or the Medical Information Bureau, Inc. (MIB).

In certain circumstances, and in compliance with applicable law, our Company may disclose personal or privileged information to third parties without your authorization.

You have the right to be told about and to see a copy, if you wish, 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.

**The above is a general description of the Company's and your agent's/broker's 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, Underwriting Department, Mutual of Omaha Plaza, Omaha, NE 68175.**

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

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every “consumer reporting agency” (CRA). Most CRAs are credit bureaus that gather and sell information about you — such as if you pay your bills on time or have filed bankruptcy — to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission’s web site (<http://www.ftc.gov>). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information for a CRA to take action against you — such as denying an application for credit, insurance, or employment — must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- **You can dispute inaccurate information with the CRA.** If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs — to which it has provided the data — of any error.) The CRA must give you a written report of the investigation, and a copy of your report if the investigation results in any change. If the CRA’s investigation does not resolve the dispute, you may add a brief statement of your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or a dispute statement filed, you may ask that anyone who has recently received your report be notified of the change.
- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate or unverified information from its files, within 30 days after you dispute it. **However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified.** If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- **You can dispute inaccurate items with the source of the information.** If you tell anyone — such as a creditor who reports to a CRA — that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you’ve notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.
- **Outdated information may not be reported.** In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- **Access to your file is limited.** A CRA may provide information about you only to people with the need recognized by the FCRA — usually to consider an application with a creditor, insurer, employer, landlord, or other business.
- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report information about you to creditors, insurers, or employers without your permission.
- **You may choose to exclude your name from a CRA list for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete and return the CRA form provided for this purpose, you must be taken off the list indefinitely.
- **You may seek damages from violators.** If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

GIVE COPY TO THE APPLICANT

The FCRA gives several different federal agencies authority to enforce the FCRA:

**For Questions or Concerns Regarding:**

CRAs, creditors and others not listed below

National banks, federal branches/agencies of foreign banks  
(word “National” or initials “N.A.” appear in or after bank’s name)

Federal Reserve System member banks (except national banks,  
and federal branches/agencies or foreign banks)

Savings associations and federally chartered savings banks,  
(word “Federal” or initials “F.S.B.” appear in federal  
institution’s name)

Federal credit unions (words “Federal Credit Union” appear  
in the institutions name)

State-chartered banks that are not members of the  
Federal Reserve System

Air, surface, or rail common carrier regulated by former  
Civil Aeronautics Board or Interstate Commerce Commission

Activities subject to Packers and Stockyards Act, 1921

**Please Contact:**

Federal Trade Commission  
Consumer Response Center — FCRA  
Washington, DC 20580  
202-326-3761

Office of the Comptroller of the Currency  
Compliance Management, Mail Stop 6-6  
Washington, DC 20219  
800-613-6743

Federal Reserve Board  
Division of Consumer & Community Affairs  
Washington, DC 20551  
202-452-3693

Office of Thrift Supervision  
Consumer Programs  
Washington, DC 20552  
800-842-6929

National Credit Union Administration  
1775 Duke Street  
Alexandria, VA 22314  
703-518-6360

Federal Deposit Insurance Corporation  
Division of Compliance & Consumer Affairs  
Washington, DC 20429  
800-934-FDIC

Department of Transportation  
Office of Financial Management  
Washington, DC 20590  
202-366-1306

Department of Agriculture  
Office of Deputy Administrator — GIPSA  
Washington, DC 20250  
202-720-7051



# Acknowledgment Form



United of Omaha Life Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175  
402 342 7600

<b>Name of Proposed Insured:</b> <b>Age</b> <b>Sex</b>	<b>Name of Applicant (if other than Proposed Insured):</b>
<b>Address of Proposed Insured:</b>	<b>Address of Applicant (if other than Proposed Insured):</b>
<b>City:</b> <b>State:</b> <b>ZIP:</b>	<b>City:</b> <b>State:</b> <b>ZIP:</b>

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

- no illustration was used in the sale of the life insurance policy applied for;
- OR
- the life insurance policy applied for is other than as shown in the policy illustration.

\_\_\_\_\_  
Signature of Agent/Broker

\_\_\_\_\_  
Date

I, the applicant, acknowledge that (check only one):

- no policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered;
- OR
- the policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Applicant  
(if other than Proposed Insured)

\_\_\_\_\_  
Date

Submit This Copy To The Company

# Acknowledgment Form



United of Omaha Life Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175  
402 342 7600

<b>Name of Proposed Insured:</b> <b>Age</b> <b>Sex</b>	<b>Name of Applicant (if other than Proposed Insured):</b>
<b>Address of Proposed Insured:</b>	<b>Address of Applicant (if other than Proposed Insured):</b>
<b>City:</b> <b>State:</b> <b>ZIP:</b>	<b>City:</b> <b>State:</b> <b>ZIP:</b>

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

- no illustration was used in the sale of the life insurance policy applied for;
- OR
- the life insurance policy applied for is other than as shown in the policy illustration.

\_\_\_\_\_  
Signature of Agent/Broker

\_\_\_\_\_  
Date

I, the applicant, acknowledge that (check only one):

- no policy illustration was provided to me and I understand that a policy illustration conforming to the policy as issued will be provided no later than the time the policy is delivered;
- OR
- the policy applied for is different than the policy illustration shown to me, and I understand that a policy illustration conforming to the policy as issued will be provided no later than at the time the policy is delivered.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Proposed Applicant  
(if other than Proposed Insured)

\_\_\_\_\_  
Date

Give This Copy To The Client



**MUTUAL OF OMAHA INSURANCE COMPANY  
UNITED OF OMAHA LIFE INSURANCE COMPANY  
UNITED WORLD LIFE INSURANCE COMPANY**

- ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
- ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

**NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND  
CONSENT FOR TESTING**

**THE HIV ANTIBODY TEST**

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. A series of tests will be performed by a licensed laboratory through a medically accepted procedure.

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-six months.

**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.

**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

1st Copy — Proposed Insured

Page 1 of 3



**MUTUAL OF OMAHA INSURANCE COMPANY  
UNITED OF OMAHA LIFE INSURANCE COMPANY  
UNITED WORLD LIFE INSURANCE COMPANY**

- ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
- ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
- ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

**NOTICE OF AIDS VIRUS (HIV) ANTIBODY TESTING AND  
CONSENT FOR TESTING**

**THE HIV ANTIBODY TEST**

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. A series of tests will be performed by a licensed laboratory through a medically accepted procedure.

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-six months.

**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.

**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

**COUNSELING RESOURCES LIST**

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

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

# United of Omaha Life Insurance Company

## Summary of Premium Provisions Statement of Understanding

United of Omaha's portfolio of renewable term products provides level protection for either 5, 10, 15 or 20 years and may be renewed yearly at the rates in effect for the attained age of the insured on each anniversary of the coverage. This also applies to any Other Insured Rider that may be attached to these products.

I understand that the premiums for the policy and, if applicable, the Other Insured Rider for which I am applying are guaranteed for **only**:

- The first five policy years
- The first ten policy years
- The first fifteen policy years
- The first twenty policy years

I further understand that the current schedule of premiums may change. After the guaranteed period checked above, the policy will be an adjustable premium life insurance policy. The initial premiums for both the policy and any Other Insured Rider are guaranteed for the period checked above. Thereafter, on the anniversary of the coverage, the current schedule of premiums for both the policy and any Other Insured Rider may stay the same, go down or go up, but will never be higher than the maximums guaranteed at the time of issue.

United of Omaha reserves the right to charge the maximum premiums beginning with any premium redetermination date. The redetermined premiums, if less than the maximum premiums stated in the policy, are not guaranteed beyond the current redetermination period.

United of Omaha's renewable term plans and Other Insured Rider provide an even lower schedule of premiums if the applicant and/or Other Insured qualifies for the nontobacco or preferred ratings.

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

(In compliance with regulations of your state, this Summary must accompany any application for the renewable term coverage.)



## UNITED OF OMAHA LIFE INSURANCE COMPANY

### NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

#### UNMARRIED RESIDENT

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

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

#### MARRIED RESIDENT

**COMMUNITY SPOUSE RESOURCE ALLOWANCE:** If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than \$89,000.

**MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE:** If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income, or \$2,175 in monthly income, whichever is greater.

#### FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than \$89,000 in countable resources. The order also may allow the at-home spouse to retain more than \$2,175 in monthly income.

#### REAL AND PERSONAL PROPERTY EXEMPTIONS

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

#### REAL PROPERTY EXEMPTIONS

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

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

- **REAL PROPERTY USED IN A BUSINESS OR TRADE.** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

## **PERSONAL PROPERTY AND OTHER EXEMPT ASSETS**

- **IRAs, KEOGHs, AND OTHER WORK-RELATED PENSION PLANS.** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- **PERSONAL PROPERTY USED IN A TRADE OR BUSINESS.**
- **ONE MOTOR VEHICLE.**
- **IRREVOCABLE BURIAL TRUSTS OR IRREVOCABLE PREPAID BURIAL CONTRACTS.**

### **THERE MAY BE OTHER ASSETS THAT MAY BE EXEMPT.**

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

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

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

## **ASSET LIQUIDATION OR SALE DISCLOSURE**

California Insurance Code §789.8 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.





## UNITED OF OMAHA LIFE INSURANCE COMPANY

### NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

#### UNMARRIED RESIDENT

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

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

#### MARRIED RESIDENT

**COMMUNITY SPOUSE RESOURCE ALLOWANCE:** If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than \$89,000.

**MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE:** If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or \$2,175 in monthly income, whichever is greater.

#### FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than \$89,000 in countable resources. The order also may allow the at-home spouse to retain more than \$2,175 in monthly income.

#### REAL AND PERSONAL PROPERTY EXEMPTIONS

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

#### REAL PROPERTY EXEMPTIONS

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

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

- **REAL PROPERTY USED IN A BUSINESS OR TRADE.** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

**PERSONAL PROPERTY AND OTHER EXEMPT ASSETS**

- **IRAs, KEOGHs, AND OTHER WORK-RELATED PENSION PLANS.** These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- **PERSONAL PROPERTY USED IN A TRADE OR BUSINESS.**
- **ONE MOTOR VEHICLE.**
- **IRREVOCABLE BURIAL TRUSTS OR IRREVOCABLE PREPAID BURIAL CONTRACTS.**

**THERE MAY BE OTHER ASSETS THAT MAY BE EXEMPT.**

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

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

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_  
 (Applicant’s signature)

Signature: \_\_\_\_\_  
 (Spouse or legal representative)

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

**ASSET LIQUIDATION OR SALE DISCLOSURE**

California Insurance Code §789.8 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.

**United of Omaha Life Insurance Company**

**ACCELERATED BENEFIT RIDER DISCLOSURE**

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

This rider is part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the rider provisions. This rider is effective on the policy's date of issue.

**Accelerated Benefit**

While this rider is in force, you may make a one-time election to receive the Accelerated Benefit if the Insured is diagnosed as having a Terminal Illness. Terminal Illness means a medical condition that, with 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.

The Accelerated Benefit amount will equal:

- (a) 94% of the net death benefit of the policy; plus
- (b) 94% of any term insurance rider on the Insured's life that is attached to the policy.

There is no premium or cost of insurance charge for this benefit.

The Accelerated Benefit is not available if the sum of the death benefit under the policy and the death benefit under any term insurance rider on the Insured's life is greater than \$500,000.

Term life insurance riders, if attached to the base plan, will be terminated, but are included in the Accelerated Benefit calculation. Non-term life insurance riders such as the Accidental Death Benefit will terminate when the Accelerated Benefit option is invoked.

Any outstanding loans will be deducted from the death benefit before the Accelerated Benefit is calculated.

**Termination**

The policy and all riders attached to it will terminate when the Accelerated Benefit is paid. Any rider that covers the life of another person and that includes a conversion provision may be converted to a new policy as specified in the rider.

This rider will terminate on the earliest of the following:

- (a) the date the Accelerated Benefit is paid;
- (b) the date the policy terminates; or
- (c) the maturity date of the policy.

I acknowledge receipt of this Disclosure Form.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

I have provided this Disclosure Form to the Applicant.

\_\_\_\_\_  
Producer Signature

\_\_\_\_\_  
Date

**Meanings of Terms**

**"MIB Group, Inc. (MIB)" means:** a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

**"Personal Information" means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

**"Specified Companies" means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

**Authorization to Receive and Disclose**

To the MIB:

I authorize you to disclose Personal Information about me (the undersigned) or my children to the Specified Companies and their reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with one or more of the Specified Companies.

I also authorize the Specified Companies and their reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the 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.

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

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:

Attn: Individual Underwriting  
Mutual of Omaha  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

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

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (If Proposed Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date