**United of Omaha Life Insurance Company**
A Mutual *of* Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

# APPLICATION for LIVING PROMISE

## Helping with Final Expenses and More!

**Alaska**
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**Georgia**
**Iowa**
**Idaho**
**Indiana**
**Kentucky**
**Louisiana**
**Massachusetts**
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**Mississippi**
**Nebraska**
**Ohio**
**South Carolina**
**Tennessee**
**Texas**
**Utah**
**Wisconsin**
**West Virginia**
**Wyoming**



LAP1162_0613
05/16/2014

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

# ✍ *CHECKLIST FOR SUBMITTING A COMPLETED APPLICATION*

Please mail application and appropriate forms to:

**For regular mail submission:**
United of Omaha Life Insurance Company
Attn: Individual Life Underwriting
P.O. Box 2476, Omaha, NE 68103-2476

**For overnight submission:**
United of Omaha Life Insurance Company
Attn: Individual Life Underwriting
9330 State Hwy 133, Blair, NE 68008

**For Fax submission:**
Fax to 1-402-997-1800 and verify that the correct fax number is dialed to protect the privacy of the information contained in the application/forms. Use the maximum resolution to ensure the readability of the application.

☐ **Application**
1 Answer all questions completely and legibly.
2 Be sure the application is signed and dated in all places indicated by the Proposed Insured and the applicant if other than the Proposed Insured.
3 Any changes should be initialed by the Proposed Insured and, if applicable, the Applicant.
4 Use age last birthday.

☐ **Have client sign HIPAA/MIB Authorization**
Submit the 'Authorization to Disclose Personal Information' (Combo HIPAA/MIB Authorization) with application.

☐ **Complete Premium Collection Section**
A full modal premium is collected at the time of application unless the Automated Bank Account Withdrawal option is selected.

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

☐ **Complete the Accelerated Death Benefit Rider Disclosure**
Provide an Accelerated Death Benefit Rider Disclosure only if applying for the level death benefit.

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

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

# United of Omaha Life Insurance Company

A Mutual of Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

## Application for Individual Life Insurance

### PROPOSED INSURED

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

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

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

| Are you a legal resident of the United States? ☐ **Yes** ☐ **No** **(if "No", you are not eligible for coverage)** | **In the past 12 months**, has the Proposed Insured used any form of tobacco or nicotine replacement therapy? ☐ **Yes** ☐ **No** |
|---|---|

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

| Name of Policyowner (First, Middle Initial, Last) | Relationship to Proposed insured |
|---|---|
| | |

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

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

### UNDERWRITING

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

| | |
|---|---|
| **1.** Is the Proposed Insured currently: | |
| **(a)** bedridden or confined to any hospital, nursing home, long-term care facility or skilled nursing facility; or receiving or been advised to receive care in a nursing home, hospice care, or home health care? . . . . | ☐ **Yes** ☐ **No** |
| **(b)** requiring assistance with activities of daily living such as taking medications, bathing, dressing, eating, toileting, getting in and out of a chair or bed, or control of bowel or bladder problems? . . . . . | ☐ **Yes** ☐ **No** |
| **(c)** requiring any of the following (other than for fractures, bone or joint surgery, including replacement): wheelchair, electric scooter, or oxygen equipment to assist breathing (excluding use for sleep apnea)? . . . . . | ☐ **Yes** ☐ **No** |
| **2.** Has the Proposed Insured **ever been**: | |
| **(a)** diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or heath care provider? . . . . . | ☐ **Yes** ☐ **No** |
| **(b)** diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Quadriplegia, Paraplegia, Down's Syndrome, mental incapacity, congestive heart failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type? . . . . . | ☐ **Yes** ☐ **No** |
| **(c)** diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed with End Stage Renal Disease or requiring dialysis?. . . . . | ☐ **Yes** ☐ **No** |
| **(d)** advised to receive or have received an organ or bone marrow transplant?. . . . . | ☐ **Yes** ☐ **No** |
| **(e)** diagnosed by a physician or health care provider as having a terminal medical condition that is expected to result in death within the next twelve (12) months?. . . . . | ☐ **Yes** ☐ **No** |
| **3.** In the past 12 months, has the Proposed Insured been: | |
| **(a)** advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known? . . . . . | ☐ **Yes** ☐ **No** |
| **(b)** diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind? . . | ☐ **Yes** ☐ **No** |
| **4.** In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for any form of cancer (except basal or squamous cell skin cancer)? . . . . . | ☐ **Yes** ☐ **No** |

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

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

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

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

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

## PLAN INFORMATION

| Plan: | Rider: (Only if selecting Level Benefit Product) |
|---|---|
| ☐ Level Benefit Product ☐ Graded Benefit Product<br>Amount Applied For $ _____ | ☐ Accidental Death Rider |

Payment Mode:

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

Modal Premium $_____ Collected Premium $_____

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

| Primary Beneficiary | Relationship to Insured | Date of Birth |
|---|---|---|
| | | |
| **Contingent Beneficiary** | **Relationship to Insured** | **Date of Birth** |
| | | |

## OTHER COVERAGE INFORMATION

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

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

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

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

## AGREEMENT

**1.** The undersigned agree(s) that (a) all answers in this application are true and complete to the best of my knowledge and belief; (b) United of Omaha Life Insurance Company ("United of Omaha") will rely on these answers to determine insurability; and (c) incorrect or misleading answers may void this application and any issued policy effective the issue date.

**2.** The undersigned acknowledge(s) that United of Omaha may require medical records, an underwriting assessment, a medical examination, or other information.

**3.** The undersigned agree(s) that United of Omaha will not issue a policy as a result of this application unless (a) the Proposed Insured completes all medical examinations and tests required by United of Omaha; (b) United of Omaha receives any additional information requested for underwriting; and (c) the Proposed Insured is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the Proposed Insured or the Applicant (if other than the Proposed Insured) has subsequently accepted an offer by United of Omaha for coverage other than as applied for, according to the underwriting standards of United of Omaha then in force.

**4.** The undersigned agree(s) that this application does not provide temporary or interim insurance prior to policy issuance. If the undersigned has made an advance premium payment, undersigned agree(s) to the terms and conditions of the Conditional Receipt. The undersigned agree(s) that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. The undersigned acknowledge(s) that if this application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to the Proposed Insured or the Applicant (if other than the Proposed Insured), without interest. No insurance coverage will be in effect until United of Omaha (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.

**5.** A completed and signed application will become part of the Proposed Insured's policy or the Applicant's policy (if other than the Proposed Insured).

**6.** The undersigned acknowledge(s) that no producer can (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.

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.

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

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

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

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

Signed at: _____
City State

_____ Date: _____
Signature of Proposed Insured

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

## Producer Statement:

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

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

Has the Proposed Insured informed you, the Producer(s), that he/she has any pending applications or existing life insurance or annuity contracts with the company or any other company?. . . . . ☐ **Yes** ☐ **No**

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

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

**If "Yes," state relationship** _____

How long have you known the Proposed Insured? _____

How long have you known the Proposed Owner? _____

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Signature of Producer #1 | Producer E-mail | Production Number | Date |
| _____ | _____ | _____ | _____ |
| Signature of Producer #2 | Producer E-mail | Production Number | Date |

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

## Producer Statement

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

**2** I conducted said interview in person ..... ☐ Yes ☐ No

**If "No," please explain** _____

_____

**3** List any additional information or comments below:

_____

_____

_____

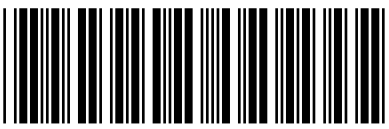
_____

_____

_____

_____





# United of Omaha Life Insurance Company

Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

## PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: _____ Policy Number(s) if known: _____

**Complete this form only when authorizing a bank account withdrawal for premium payment.**

### Payment Information

1. **Initial Monthly Premium Payment (select only one option)** Amount Quoted $_____
   - ☐ Draft premium immediately upon approval/issue
   - ☐ Draft initial premium on or after: _____/_____/_____ (Please Note: If policy issue is after date selected, premium will be withdrawn on the policy issue date or receipt of delivery requirements)
   - ☐ Check collected and mailed to Mutual of Omaha

   When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT AS STATED ABOVE. The first Withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. We **CANNOT** establish electronic payments from foreign banks.

2. **Ongoing Premium Payments**- Automated Bank Account Withdrawal (Monthly)
   Specify the date ongoing premiums will be withdrawn: (1st through the 28th of each month) _____
   Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

### Payor Information

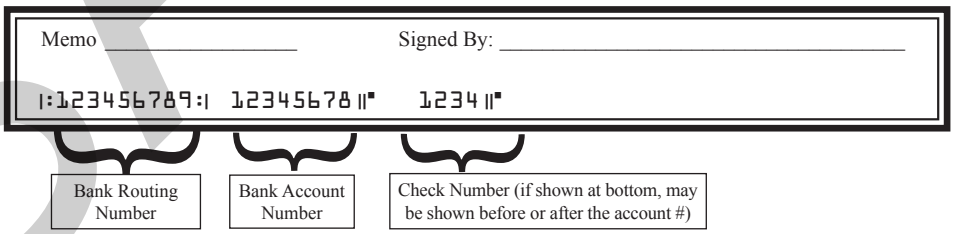
Name of payor as shown on bank account: _____ Social Security No._____

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation required)

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

### Account Information

1. Account Type (check one): ☐ Checking ☐ Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check here.
   Bank Routing Number: _____ Bank Account Number: _____
   (Do not use Debit/Credit Card numbers)




### Authorization

I authorize United of Omaha Life Insurance Company ("United of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to United of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, United of Omaha may require written confirmation from me within 14 days after my verbal notice.

Date _____ X _____

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

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

## AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB Inc., state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me and my children, if they are proposed insureds (My Children), to release Personal Information about me or My Children to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

The Personal Information will be used to determine my and My Children's eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual, or its reinsurers, to disclose my and My Children's personal Information to MIB, Inc. I understand that my and My Children's Personal Information received by MIB, Inc. may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that if the person or entity to whom Personal information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal information may be redisclosed without the protection of the federal privacy regulations.

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

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Proposed Insured acknowledges and agrees that if there is more than one Proposed Insured on this application, all information provided may be reviewed or shared with the other Proposed Insured. A completed and signed application will become part of each insured's policy.

**Name(s) used for medical records (if different than the name) below:** _____

_____

_____ **Date:** _____
Signature of Proposed Insured Mo Day Yr

_____ **Date:** _____
Signature of Spouse (if Proposed Insured) Mo Day Yr

_____ **Date:** _____
Signature of Parent or Guardian (if Proposed Insured is a Minor) Mo Day Yr

_____ **Date:** _____
Signature of Non-minor Child (if Proposed Insured is a Non-minor) Mo Day Yr

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS**

L8232_0913

# Conditional Receipt ("Receipt")

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

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

**Date of Receipt:**_____

**Benefit**

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) $40,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed $40,000.

**Conditions**

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

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

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

**End Date**

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

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

**Signatures**

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

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

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

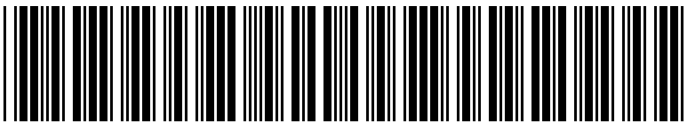
_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

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

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

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date



# ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

**The benefit received under the rider may be taxable. Receipt of the accelerated death benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting the benefit.**

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness or Nursing Home Confinement 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 the insured has a terminal illness or is under nursing home confinement, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. Nursing home confinement means that the insured has been confined to a nursing home for at least 90 consecutive days and is expected to remain confined for the remainder of his or her life. A physician must certify that the insured has a terminal illness or is under nursing home confinement.

The amount available for the accelerated death benefit is your policy's death benefit. You may receive the accelerated death benefit only once.

For a terminal illness, we will reduce the accelerated death benefit by 6%.

For nursing home confinement, we will reduce the accelerated death benefit by the nursing home confinement factor. The nursing home confinement factor varies by policy year as shown in the rider. We will also reduce the accelerated death benefit by a $100 charge and by the amount of any loans and unpaid premiums.

## EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

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

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

### Acknowledgment

I acknowledge receipt of this disclosure form.

_____ _____
Applicant/Owner Signature Date

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

_____ _____
Producer Signature Date

CLIENT FORMS

# IMPORTANT DOCUMENTS

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

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s).



# Conditional Receipt ("Receipt")

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

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

**Date of Receipt:**_____

**Benefit**

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) $40,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed $40,000.

**Conditions**

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

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

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

**End Date**

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

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

**Signatures**

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

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

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

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

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

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

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date

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

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

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

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.**

L8303

## MIB, Inc. Pre-Notice

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

Upon receipt of a request from you MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

United of Omaha Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

L7941

## 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 609 (c) 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.

L7942_0812

GIVE THESE NOTICES TO THE APPLICANT

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

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

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

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

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

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



**GIVE THIS COPY TO THE APPLICANT**

# ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

**The benefit received under the rider may be taxable. Receipt of the accelerated death benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting the benefit.**

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness or Nursing Home Confinement 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 the insured has a terminal illness or is under nursing home confinement, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. Nursing home confinement means that the insured has been confined to a nursing home for at least 90 consecutive days and is expected to remain confined for the remainder of his or her life. A physician must certify that the insured has a terminal illness or is under nursing home confinement.

The amount available for the accelerated death benefit is your policy's death benefit. You may receive the accelerated death benefit only once.

For a terminal illness, we will reduce the accelerated death benefit by 6%.

For nursing home confinement, we will reduce the accelerated death benefit by the nursing home confinement factor. The nursing home confinement factor varies by policy year as shown in the rider. We will also reduce the accelerated death benefit by a $100 charge and by the amount of any loans and unpaid premiums.

## EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

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

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

### Acknowledgment

I acknowledge receipt of this disclosure form.

_____ _____
Applicant/Owner Signature Date

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

_____ _____
Producer Signature Date

## United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

# Replacement of Life Insurance or Annuities

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

### Premiums:

- Are they affordable?
- Could they change?
- You're older—are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

### Policy Values:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

### Insurability:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

### If you are keeping the old policy as well as the new policy:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

### If you are surrendering an annuity or interest sensitive life product:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

### Other issues to consider for all transactions:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

THIS REPLACEMENT FORM REQUIRED IF APPLICANT/OWNER HAS ANY EXISTING LIFE OR ANNUITY CONTRACTS

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

## Important Notice: Replacement of Life Insurance or Annuities

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? . . . . . ❑ YES ❑ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? . . . . . ❑ YES ❑ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

| Insurer Name | Contract or Policy # | Insured or Annuitant | Replaced (R) or Financing (F) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____

_____

If you are replacing, list below the form number(s) and brief description(s) of preprinted or electronic sales material which was presented, or check "NONE" box if no sales material was used in this sale: . . . . . ❑ NONE
(The producer must provide the applicant with a copy of all sales material used at time of application, including electronically presented sales material in printed form no later than the time of policy or contract delivery.)

_____

_____

I certify that the responses herein, to the best of my knowledge, are accurate.

| **Applicant** | **Applicant B (if applicable)** |
|---|---|
| Printed Name of Proposed Applicant/Owner | Printed Name of Proposed Applicant/Owner |
| Signature of Proposed Applicant/Owner | Signature of Proposed Applicant/Owner |
| Date | Date |

_____ _____ _____

Producer's Signature | Producer's Printed Name | Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

THIS REPLACEMENT FORM REQUIRED IF APPLICANT/OWNER HAS ANY EXISTING LIFE OR ANNUITY CONTRACTS

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

## Important Notice: Replacement of Life Insurance or Annuities

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? . . . . . ❑ YES ❑ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? . . . . . ❑ YES ❑ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

| Insurer Name | Contract or Policy # | Insured or Annuitant | Replaced (R) or Financing (F) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____

_____

If you are replacing, list below the form number(s) and brief description(s) of preprinted or electronic sales material which was presented, or check "NONE" box if no sales material was used in this sale: . . . . . ❑ NONE
(The producer must provide the applicant with a copy of all sales material used at time of application, including electronically presented sales material in printed form no later than the time of policy or contract delivery.)

_____

_____

I certify that the responses herein, to the best of my knowledge, are accurate.

| **Applicant** | **Applicant B (if applicable)** |
|---|---|
| Printed Name of Proposed Applicant/Owner | Printed Name of Proposed Applicant/Owner |
| Signature of Proposed Applicant/Owner | Signature of Proposed Applicant/Owner |
| Date | Date |

_____ _____ _____

Producer's Signature | Producer's Printed Name | Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

Company's Copy

L6232_0513

**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.

_____

_____

_____

_____

_____

_____