NEW BUSINESS MEMO
PROVIDER WHOLE LIFE

United Home Life Insurance Company
Simplified Products - Faster Results

Telephone: 800-428-3001

Regular Mail:
United Home Life Insurance Company
P.O. Box 7192
Indianapolis, IN 46207-7192

Overnight Mail:
United Home Life Insurance Company
225 South East St
Indianapolis, IN 46202

FAX Number: 317-692-7711 _____ # pages including cover

Agt Name: _____ Agt # _____

Agt Phone: _____ Agt Fax: _____

Agt Email Address: _____@_____._____

How do you prefer to be notified if we should need any underwriting requirements?
☐ E-Mail ☐ Fax ☐ US Mail

Street _____ City _____ State _____ Zip Code_____

Did you personally see all persons proposed for insurance and personally view a photo ID (driver's license, passport) of the proposed owner and/or insured? ☐ Yes ☐ No

If No, how was the application taken? Solicited by: ☐ Mail ☐ Telephone ☐ Internet ☐ Fax or Other _____

Did you identify any unusual behavior or suspicious activity by the proposed owner or insured? ☐ Yes ☐ No

If Yes, please explain. _____

PHI'S: We require Personal History Interviews on all Applicants for this plan of insurance. As the agent, you can initiate the interview from the client's home by calling 866-333-6557 (M-F, 8:30 a.m.-8:30 p.m. EST). Tell the operator this interview is for United Home Life Insurance Company. A traditional PHI will be ordered by the Home Office if a Point of Sale PHI is not completed by you. Detailed explanation is on our website at www.unitedhomelife.com.

Did you complete a POS PHI with your client? ☐ Yes ☐ No

If we have to conduct a PHI with your client, what is the best time to reach the client?

Home phone (_____) _____available days? ☐ Yes ☐ No
Business phone (_____) _____available days? ☐ Yes ☐ No
Cell phone (_____) _____available days? ☐ Yes ☐ No

If a language other than English is required, please specify below.

Effective November 1st, to comply with your states' requirement that we secure proof that your clients' life insurance policies have been delivered to them, we are doing the following:

All issued policies will be sent directly to your clients' home addresses via Certificates of Mailing. These certificates represent satisfactory proof to your Departments of Insurance that UHL has mailed the policies to your clients.

If you would like further information about our decision, please call us at 800-428-3001 (extension 7724).

Special Instructions you want us to know:

_____

_____

_____

_____

_____

Application Completion "Tips"

1. Make sure to use the app with the correct state variations
2. Make sure to obtain signature of the proposed Insured age 15 and older.
3. If Child Rider is requested, submit application 200-359
4. If the first premium is going to be drafted from the client's bank account, *provide a copy of a voided check!* Otherwise, the case will be unnecessarily delayed
5. Print legibly in English
6. Keep original app until policy is issued
7. Keep fax confirmation message that fax was successful

MAIL POLICY TO: ☐ Applicant ☐ Agent

200-536 4-09 (LA)

Provider Whole Life Insurance Application

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

1. Last Name	First Name	Middle Initial	Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female

Marital Status	Height	Weight	Social Security Number	Drivers License No. _____ State _____	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:* _____

Street Address	City	State	Zip Code	Phone Number ( )

2. Employer/Occupation/Duties/How Long There	**2.a.** How many hours worked per week?

3. Beneficiary Name (for the Face Amount listed in 6.b.)	Relationship	Age
a. Primary		
b. Contingent		

4.a. Owner Name	Relationship	Social Security Number

Owner Street Address	City	State	Zip Code

4.b. Contingent Owner Name	Relationship	Social Security Number

5. Billing Street Address	City	State	Zip Code

Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code

6.a. Plan of Insurance: Provider

6.b. Face Amount: $_____

If this face amount is $25,000 or greater, the Company will issue the policy with a face amount 1% higher at no additional charge. The corresponding increase in death benefit will be paid to the Charitable Gift Beneficiary you designate below.

6.c. If the Face Amount shown above is $25,000 or greater:

1. List the Charitable Gift Beneficiary
   Name _____ Address _____
   (If none chosen, Charitable Gift Beneficiary will be American Red Cross.)
2. The following benefits will be attached to the policy: Life Threatening Cancer Accelerated Benefit Rider and Common Carrier Accidental Death Benefit Rider.

6.d. If the issue age of the proposed insured is 17 years or less, the following benefit will be attached to the policy: Guaranteed Insurability Benefit Rider.	**6.e.** Waiver of Premium ❑	**6.f.** Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Qtrly. ❑ PAC Modal Premium Amount $

7. Do you have any existing life insurance policies or annuity contracts? ❑ Yes ❑ No If "Yes," please complete any necessary replacement forms.

8. Name of physician last consulted and name of family physician if different: **(Required)**

Physician _____ Date _____

Address _____ Phone No. ( ) _____

Reason, Diagnosis and/or Treatment _____

Family Physician _____

9. Have you:	
a. used nicotine in any form in the past 12 months? If yes, indicate type ❑ cigarettes ❑ cigars ❑ pipe ❑ chewing ❑ snuff ❑ other _____ (nicotine replacement products)	❑ Yes ❑ No
b. Used nicotine in any form in the past and quit? If yes, date last used? _____	❑ Yes ❑ No
10. In the past 10 years have you had or been diagnosed or treated for any disease or disorder of:	
a. throat, nose, lungs or respiratory system such as tuberculosis, shortness of breath, asthma, bronchitis, chronic obstructive pulmonary disease, emphysema, or sleep apnea?	❑ Yes ❑ No
b. heart, circulatory, cerebrovascular system such as high or low blood pressure, chest pain, heart attack, coronary artery disease, congestive heart failure, heart murmur, stroke, TIA (Transient Ischemic Attack), peripheral vascular disease, anemia, Sickle Cell Anemia?	❑ Yes ❑ No

10. (continued)

c. digestive system (stomach, intestines, rectum, liver, pancreas, gallbladder) such as ulcer, colitis, Crohn's disease, hepatitis B & C, cirrhosis or pancreatitis?	❑ Yes ❑ No
d. brain, nervous system, paralysis, convulsions, seizures, epilepsy or mental disorders such as depression, anxiety, Schizophrenia, Bipolar disorder, suicide attempt, eating disorder, multiple sclerosis, Alzheimer's disease, or dementia?	❑ Yes ❑ No
e. kidney, urinary, bladder, reproductive, breast or prostate disorders such as kidney disease, stone, colic, stricture, sexually transmitted disease?	❑ Yes ❑ No
f. muscles, bones, joints, skin such as arthritis, rheumatoid arthritis, fractures, back problems, lupus, ALS-Lou Gehrig's Disease?	❑ Yes ❑ No
g. cancer, tumor or polyps, melanoma or other malignancy?	❑ Yes ❑ No
h. endocrine system such as diabetes, thyroid disorder, goiter?	❑ Yes ❑ No
i. eyes or ears such as impaired sight or hearing?	❑ Yes ❑ No
j. AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex) or AIDS related conditions or any other immune disorders?	❑ Yes ❑ No
11. Have you:	
a. had a chronic cough, significant weight change (more than 10 lbs. other than normal growth for children), chronic fatigue, diarrhea or enlarged glands within the past two years?	❑ Yes ❑ No
b. had an electrocardiogram, x-ray, blood test, urinalysis or any other diagnostic tests within the past 5 years?	❑ Yes ❑ No
c. tested positive for antibodies to the AIDS (Human T-cell Lymphtropic Type III HTL V-II) virus within the past ten years?	❑ Yes ❑ No
d. consulted a medical practitioner or received hospital or sanitarium care in the past 5 years other than listed in Section 8?	❑ Yes ❑ No
e. been declined, postponed, limited or had a policy issued other than as applied for on any life, health or disability insurance or reinstatement thereof in the past 5 years?	❑ Yes ❑ No
f. had surgical procedure, been advised to have or contemplated any surgical procedure, operation or organ transplant within the past ten years?	❑ Yes ❑ No
g. been rejected, deferred or discharged by the armed forces for a physical or mental condition?	❑ Yes ❑ No
h. used (other than prescribed by a physician) narcotics, LSD, cocaine, amphetamines, barbiturates or marijuana; or been dependent upon or excessively used, alcohol, drugs or narcotics (whether prescribed by a physician or not); or been treated, or been advised to seek treatment or counseling for alcohol or drug usage; or been arrested or awaiting trial for DUI or substance violation?	❑ Yes ❑ No
i. had a driver's license revoked or suspended or ever been arrested or convicted for other than a misdemeanor; or had in the past two years two or more moving violations or two or more vehicle accidents?	❑ Yes ❑ No
j. engaged in or contemplated engaging in sky diving, racing, any other hazardous sport or any type of flying as a pilot or crew member in the past five years?	❑ Yes ❑ No
k. applied for or received any kind of benefits, pension or disability for any injury, sickness or impaired condition in the past five years?	❑ Yes ❑ No
l. had any application for any other life, health or disability income insurance now pending or contemplated with this company or any other company?	❑ Yes ❑ No
12. Are you:	
a. currently taking any medications? (indicate type and dosage in Section 14)	❑ Yes ❑ No
b. currently pregnant, if female? (If yes, include due date _____)	❑ Yes ❑ No
c. now under the observation of a medical practitioner or receiving any kind of medical treatment?	❑ Yes ❑ No
d. aware of any symptoms for which you have not yet consulted a medical practitioner?	❑ Yes ❑ No
13. Do your parents or siblings now have or had in the past: cancer, heart or kidney disease or any other hereditary disease prior to age 60? If yes, give details below.	❑ Yes ❑ No

Relationship	Age if living	Age at Death	Health Condition	Cause of Death

14. Details of "Yes" answers to any Questions:

Dates	Name and Address of Physician	Diagnosis	Treatment

I hereby apply for the insurance indicated above and I am submitting the first premium. I certify that the answers are true and accurate whether written by my own hand or not. I understand that my Policy will not be effective until the date it is issued by the Company.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

$_____ paid with application.

☐ I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount.

Dated _____ (City) _____ (State) , this _____ day of _____ (Month) , _____ (Year)

X _____ (Signature of Owner (if other than Proposed Insured)) **X** _____ (Signature of Proposed Insured)

To the best of my knowledge and belief the applicant does ☐ does not ☐ have any existing life insurance policies or annuity contracts.

☐ I certify that I have provided the proposed insured a copy of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration.

X _____ (Printed Agent Name) **X** _____ (Agent's Signature)

Agent Code _____ Agent's E-Mail _____

Agent: Phone # _____ Fax# _____ License Identification Number (____) _____ (State)

Please select one:

Underwriting Information:

☐ Standard (Juvenile Age 0-17)

☐ Standard Tobacco

☐ Standard Non tobacco

☐ Preferred Non tobacco

Check or money order must accompany. All premium checks must be made payable to United Home Life Insurance Company. Do not make check or money order payable to the agent or leave the Payee blank. Include copy of voided check for bank draft.

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

Please select ONLY one option, complete bank information and sign authorization below.

☐ Draft my account for the first premium (initial premium may be drafted upon receipt of this application). Please draft subsequent premiums on the _____ day of each month.

☐ Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day each month.
Month, Day

☐ Do NOT draft my account for the first premium. The initial premium is attached, is being mailed or will be collected on delivery. Please draft subsequent premiums on the _____ day of each month.

I understand that my policy will not be effective until the date it is issued by the Company.

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

TO: _____ Bank _____Bank Address

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry.

I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account No. _____ Date_____ Bank signature of Premium Payor _____

PLEASE DETACH AND GIVE TO APPLICANT

***If you do not receive your Policy within 60 days from the date of your application, please write to* UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192**

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

I understand that my policy will not be effective until the date it is issued by the company.

RECEIPT

Received from _____ The sum of $ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance $_____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____ , _____
Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

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

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Terminal Illness Accelerated Benefit Disclosure Statement

Benefits paid under this benefit may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit.

Description of Benefits - This Benefit provides you with the right to access the Death Benefit (discounted at interest for one year)* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

Effect on the Policy - When the accelerated benefit is paid, the policy terminates.

Example - This example is for illustration only, uses a $100,000 policy and an interest rate of 7%.* **The amounts shown are not based on your specific policy.**

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Death Benefit	$100,000.00
Less 7%	6,542.06
Accelerated Benefit	**$ 93,457.94**

*The interest rate used to discount this benefit is defined in Section A of your Terminal Illness Accelerated Benefit Rider.

Authorization for Release of Medical Information

United Home Life Insurance Company
P.O. Box 7192, Indianapolis IN 46207-7192

This authorization complies with the HIPAA Privacy Rule.

_____ _____/_____/_____

Name of proposed insured/patient **(please type or print)** Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Authorization for Release of Medical Information

United Home Life Insurance Company
P.O. Box 7192, Indianapolis IN 46207-7192

This authorization complies with the HIPAA Privacy Rule.

_____ _____/_____/_____

Name of proposed insured/patient **(please type or print)** Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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This protected health information is to be disclosed under this Authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient