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

DELAWARE -
Application for Children's Whole Life Insurance

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

Application Submission Guidelines
❑ Attach a cover letter or additional information as needed.
❑ Leave all applicable forms and Life Insurance Buyer's Guide with the Proposed Insured.
❑ Please make sure all questions are answered and signatures completed.
❑ All changes should be initialed by the Owner/Applicant.
❑ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.
Important Forms
❑ Replacement Notice – if applicable, the client must sign and retain a copy for their records
❑ Payment Authorization – Complete this form if applicable

LAP1134_DE
01/22/2018

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

APPLICATION FOR CHILDREN'S WHOLE LIFE INSURANCE

Section A Owner/Applicant

Owner/Applicant Name (First Name, Initial, Last Name)	Social Security No.	☐ Male ☐ Female
Home Address (Street, City, State, ZIP)		Date of Birth (Month, Day Year)
Phone Number	E-mail Address	

Are you a legal permanent resident of the United States?..... ☐ **Yes** ☐ **No**

Section B Beneficiary

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

If more space is needed, attach a sheet for additional details.

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

Name (First Name, Initial, Last Name)

Address (Street, City, State, ZIP)

Section D Proposed Insured(s) Information (list children ages 14 days to 17 years)

First Name, Middle Initial, Last Name	Date of Birth	Sex M/F	Coverage Amount	Premium	Owner Relationship to Insured	Legal Permanent Resident of the United States?
				$		☐Yes ☐No
				$		☐Yes ☐No
				$		☐Yes ☐No
				$		☐Yes ☐No
				$		☐Yes ☐No
				$		☐Yes ☐No
				$		☐Yes ☐No
				$		☐Yes ☐No

NOTE: Use additional sheet if necessary.

Section E Other Coverage and Replacement Information

Do any of the Proposed Insureds:

1. have any existing life insurance or annuity contracts with the company or any other company?..... ☐ Yes ☐ No
2. intend for this insurance to replace or change any existing life insurance or annuity contract with the company or any other company? ..... ☐ Yes ☐ No

If "Yes" to either question, give details below:

Proposed Insured's Name	Company	Policy Number	Will this insurance be replaced?
			☐Yes ☐No
			☐Yes ☐No

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

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Section F Health Information

Have any of the Proposed Insureds received medical care for or had:

(a) a heart or circulatory system disease, birth defect, or mental or developmental disorder including autism and Down's Syndrome?..☐ **Yes** ☐ **No**

(b) any other chronic medical condition which has required care within the past 3 years?.....☐ **Yes** ☐ **No**

NOTE: Provide details for "Yes" answers. Please include Proposed Insured's name and illness or condition. (Use additional sheet if necessary.)

Proposed Insured's Name	Details of Illness or Condition

Section G Premium and Billing Information

1 Amount collected $ _____ Modal Premium for Proposed Insured(s) $ _____

2 Mode of Payment: ☐ Monthly Bank Service Plan ☐ Annual ☐ Semi-Annual ☐ Quarterly

Section H Agreement

I represent that my above answers are true and complete to the best of my knowledge and belief. I also understand that this coverage will not be in force until this application is completed in full and approved by United of Omaha Life Insurance Company, and the initial premium is received during the lifetime of the Proposed Insured(s).

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

I have read and understand this Agreement Section and I approve all the answers as recorded in this application.

Signed at: _____ Today's Date: _____

City State Month Day Year

_____

Signature of Owner/Applicant

1 In addition to the above Agreement, has the Applicant informed you, the Producer(s), that any Proposed Insured has one or more existing life insurance policies and/or annuity contracts in force?.....☐ **Yes** ☐ **No**

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

If "Yes," the Producer(s) shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.

3 Have you, the Producer(s), asked each question exactly as written and recorded the answer completely and accurately? ... ☐ **Yes** ☐ **No**
(If "No," explain.) _____

4 Did you, the Producer(s), give the Applicant the Life Insurance Buyer's Guide?.....☐ **Yes** ☐ **No**
(If "No," explain.) _____

_____ _____ _____

Signature of Producer #1 Production Number Date Month Day Year

_____ _____ _____

Signature of Producer #2 Production Number Date Month Day Year

_____ _____ _____

Print or Stamp Producer #1 Name Print or Stamp Producer #2 Name Marketer/Agency Name

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United of Omaha Life Insurance Company

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

PAYMENT AUTHORIZATION FORM

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

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

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

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

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

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

Payment Information For Ongoing Payments- Automatic Bank Account Deduction

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

- ☐ Choose the day payments will be deducted every month from your bank account:
  (**1st through the 28th** or **Last Day** of every month) _____
  -OR-
- ☐ Choose the week and weekday that payments will be deducted every month from your bank account:
  (For example, 3rd Wednesday of every month)
  Week (1st, 2nd, 3rd, 4th, Last) _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____

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

Payor Information

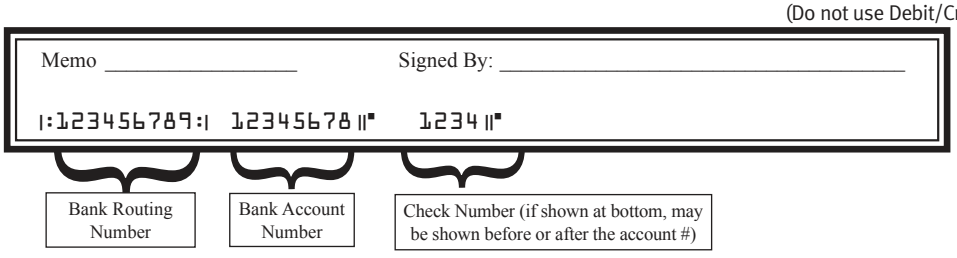
Name of payor as shown on bank account: _____

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

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

Payor Account Information

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



Payor Authorization

I authorize United of Omaha Life Insurance Company to initiate any initial or recurring preauthorized electronic transfers from my account. I understand the amounts may vary as premium shortages may result from a variety of reasons, including underwriting adjustments. This authorization will be effective until I give you at least three business days notice to cancel. If notice is given verbally, United of Omaha Life Insurance Company may require written confirmation within 15 days after my verbal notice.

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

Notice To Applicant Regarding Replacement of Life Insurance

It is in your best interest to get all the facts before making a decision. Make sure you fully understand both the proposed new policy and your existing insurance. New policies may contain provisions which limit benefits during the initial period of the contract, in particular, the suicide and incontestable clauses.

To assist you in evaluating the proposed and the existing insurance, Delaware Insurance Regulations require that the insurer advising or recommending replacement:

(a) provide the consumer, not later than the date the policy or contract is delivered, a concise summary of the policy or contract to be issued.

(b) allow a 20-day period following the delivery of the policy during which time the consumer may surrender the new policy for a full refund.

(c) advises the present insurance company (companies) of the pending replacement.

These same regulations require your present insurer to provide, on your request, a similar summary describing your present insurance.

This information will be provided automatically if you request it using the form below.

Information on Present Policies

Company Name	Policy Number*	Name of Insured	Summary Requested Mark Yes or No

(continue on reverse as required)
*Application or receipt number, if policy has not yet been issued.

It is seldom wise to terminate your existing policy until your new policy has been issued and you have examined it and found it to be acceptable.

I have read this notice and received a copy of it.

_____ _____
Applicant's/Owner's Signature Date

_____ _____
Agent's Signature Date

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Applicant's/Owner's Signature Date

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Agent's Signature Date