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

PENNSYLVANIA -
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

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)	Phone Number
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 been diagnosed or treated by a licensed member of the medical profession for:

(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

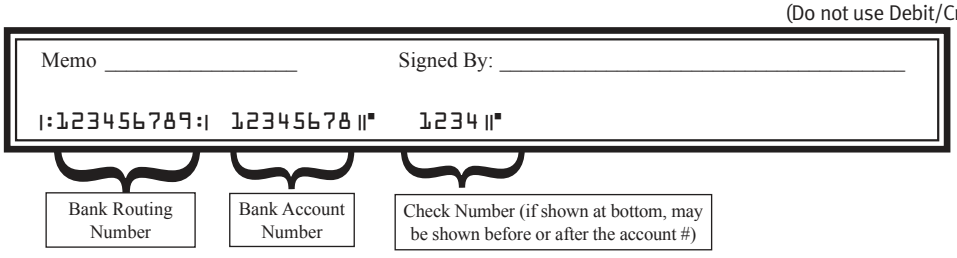
Name of payor as shown on bank account: _____

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

Disclosure Statement

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

This Disclosure Statement is for your protection. It gives you basic information about the cost and coverage of the insurance being solicited. Read it carefully before signing the accompanying application.

This Disclosure Statement shall not be considered as an offer to contract or as altering or modifying any policy or rider that may be issued.

Proposed Insured Name: _____ Sex _____ Age _____

Descriptive Title of Coverage:

Children's Whole Life Insurance paid up at age 100.

Issue ages are 14 days through 17 years. The annual policy fee is $12.00

Face Amount $_____ Annual Premium $_____

If you pay your premiums on this policy as they come due, you will have the guaranteed cash values shown on the reverse side of this form. You may borrow against this cash value at an annual interest rate of 5.66% payable in advance.

A surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one method of comparing the relative costs of two or more similar policies. If an earlier copy of the Index is necessary, call toll free 1-800-228-9999.

Upon request, the Company will furnish you with additional information about the insurance described.

I certify that a copy of this Disclosure Statement was given to the Applicant no later than the time the application was signed.

Date: _____

Licensed Agent's Signature: _____

Address: (city, state, zip) _____

Phone: _____

113700

BASIC CASH VALUES PER $1,000 OF INSURANCE*

Issue Age	MALE				FEMALE			
	At End of policy Year			At Age 65	At End of policy Year			At Age 65
	5	10	20		5	10	20	
14 days	0	9	38	416	0	9	38	416
1	0	10	40	415	0	10	40	415
2	0	10	41	414	0	10	41	414
3	0	11	43	413	0	11	44	414
4	0	12	45	412	0	12	45	412
5	0	13	47	411	0	13	47	411
6	0	14	49	410	0	14	49	410
7	0	15	52	408	0	15	52	408
8	1	16	54	407	1	16	54	407
9	1	16	56	405	1	16	56	405
10	1	17	59	404	1	17	59	404
11	2	18	62	402	2	18	62	402
12	2	19	65	401	2	19	65	401
13	2	20	67	399	2	20	67	399
14	2	20	70	397	2	20	70	397
15	2	21	74	395	2	21	74	395
16	3	23	77	393	3	23	77	393
17	3	24	81	391	3	24	81	391

* The cash values are provided to demonstrate the cash flow pattern of the policy. They do not recognize that, because of interest, a dollar in the future has less value than a dollar today.

113700

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).

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Omaha, Nebraska 68175

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	At End of policy Year			At Age 65	At End of policy Year			At Age 65
	5	10	20		5	10	20	
14 days	0	9	38	416	0	9	38	416
1	0	10	40	415	0	10	40	415
2	0	10	41	414	0	10	41	414
3	0	11	43	413	0	11	44	414
4	0	12	45	412	0	12	45	412
5	0	13	47	411	0	13	47	411
6	0	14	49	410	0	14	49	410
7	0	15	52	408	0	15	52	408
8	1	16	54	407	1	16	54	407
9	1	16	56	405	1	16	56	405
10	1	17	59	404	1	17	59	404
11	2	18	62	402	2	18	62	402
12	2	19	65	401	2	19	65	401
13	2	20	67	399	2	20	67	399
14	2	20	70	397	2	20	70	397
15	2	21	74	395	2	21	74	395
16	3	23	77	393	3	23	77	393
17	3	24	81	391	3	24	81	391

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

Notice Regarding Replacement of Life Insurance and Annuities

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months? ❑ YES ❑ NO

_____ _____
Applicant's/Owner's Signature Date

_____ _____
Agent's Signature Date

L4458_1205 Company's Copy

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A MUTUAL *of* OMAHA COMPANY

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You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

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_____ _____
Applicant's/Owner's Signature Date

_____ _____
Agent's Signature Date