



OHIO – APPLICATION FOR LIFE INSURANCE

FULLY UNDERWRITTEN PRODUCTS – One Base Policy Per Application

Checklist for Submitting a Complete Application

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

PRODUCTS	OPTIONAL RIDERS
<input type="checkbox"/> Term Life Answers (TLA)	<input type="checkbox"/> Disability Waiver of Premium Rider <input type="checkbox"/> Other Insured Rider <input type="checkbox"/> Dependent Children's Rider (\$1,000 - \$10,000) <input type="checkbox"/> Accidental Death Benefit Rider
<input type="checkbox"/> Guaranteed Universal Life (GUL) <input type="checkbox"/> AccumUL Plus <input type="checkbox"/> AccumUL Answers <input type="checkbox"/> Income Advantage (IUL) <input type="checkbox"/> Life Protection Advantage (IUL)	<input type="checkbox"/> Disability Waiver of Policy Charges <input type="checkbox"/> Disability Continuation of Planned Premium Rider <input type="checkbox"/> Guaranteed Insurability Rider (\$10,000-\$50,000) <input type="checkbox"/> Dependent Children's Rider (\$1,000 - \$10,000) <input type="checkbox"/> Accidental Death Benefit Rider <input type="checkbox"/> Additional Insured Term Rider - Self & Other Insured (AccumUL Plus, AccumUL Answers, Income Advantage & Life Protection Advantage only)

APPLICATION SUBMISSION GUIDELINES

- Attach a cover letter or additional information as needed, **AND** Always submit the Producer Statement and Producer Report page
- Always obtain signed HIPAA/MIB authorization
- Leave all applicable forms and Life Insurance Buyer's Guide with the Proposed Insured
- All changes should be initialed by the Applicant/Owner
- If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client
- If selecting the Disability Continuation of Planned Premium Rider, Accidental Death Benefit Rider, Dependent Children's Rider, Additional Insured Term Rider or the Other Insured Rider, a **RIDER AMOUNT** must be entered on the application.

IMPORTANT FORMS

- Replacement Notice – If applicable, the client must sign and retain a copy for their records
- Payment Authorization – Complete this form if applicable
- Complete two copies of the TIA form and leave the unsigned copy with the applicant when: a) all 6 questions on the TIA are answered "no"; and b) a check or electronic transaction authorization for the initial premium is collected. **DO NOT** collect a check if any of the 6 TIA questions are answered "yes" - a completed electronic transaction authorization may still be submitted. **DO NOT** complete the TIA if initial payment won't be collected until issue.
- You will need a signed Accelerated Death Benefit Rider Disclosure Form
- If face amount is \$100,000 or over, you will need a signed HIV consent form (If your state does not require the HIV Consent form, then this form will not be included in this application package)
- If face amount is \$1,000,000 and above and the Proposed Insured is age 65, or over you will need: (a) signed Statement of Policyowner form and, (b) signed Premium Funding and Acknowledgement form
- Federal Form F4506T-EZ - Used to request tax records for the insured. This form is required for applications with a face amount of greater than \$5 million and may be requested by underwriting as necessary.

SUPPLEMENTAL APPLICATIONS, FORMS & BUYER'S GUIDE

- **Child(s) Rider Supplemental Application:** If applying for the children's rider complete the Child(s) Rider Supplemental Application
- **Juvenile Life Insurance Supplemental Application:** If applying for life insurance for proposed insured ages 0-17 years
- **Indexed Universal Life Premium Allocation Form:** If applying for Income Advantage or Life Protection Advantage
- **Acknowledgment/Illustration Certification form:** Required when no illustration was used at point of sale, or the policy applied for is other than as shown in the illustration, or a computer screen illustration was displayed at point of sale but no hard copy was furnished
- **1035 Exchange:** By exercising a 1035 (a) exchange, the client may transfer the money from the old carrier to United of Omaha without incurring a taxable gain for federal income tax purposes
- **Buyer's Guide:** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale

PARAMEDICAL VENDORS	INDICATE UNDERWRITING REQUIREMENTS INITIATED OR COMPLETED ON THE PROPOSED INSURED(S)	
APPS – 1-800-635-1677 EMSI – 1-800-872-3674 EXAMONE – 1-877-933-9261	Primary Proposed Insured <input type="checkbox"/> Blood Profile <input type="checkbox"/> Urinalysis <input type="checkbox"/> Physical Data <input type="checkbox"/> MD Exam <input type="checkbox"/> Long Form Exam <input type="checkbox"/> EKG <input type="checkbox"/> Treadmill EKG	Other Proposed Insured: <input type="checkbox"/> Blood Profile <input type="checkbox"/> Urinalysis <input type="checkbox"/> Physical Data <input type="checkbox"/> MD Exam <input type="checkbox"/> Long Form Exam <input type="checkbox"/> EKG <input type="checkbox"/> Treadmill EKG

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3300 Mutual of Omaha Plaza, Omaha, NE 68175



INDIVIDUAL LIFE INSURANCE APPLICATION PART 1, PAGE 1 OF 4

PROPOSED INSURED (If Proposed Insured is age 0-17, complete the Juvenile Supplemental Application)			
Name (First, Middle Initial, Last)		Social Security Number	Gender at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (Street, City, State, ZIP)			Marital Status
Primary Phone No.	Secondary Phone No.	E-mail	
Driver's License No. (If none, please explain)			Driver's License State
Occupation/Duties		Annual Income	Employer
Date of Birth	State of Birth (Country if not U.S.)	U.S. Citizen?... <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, complete the Foreign National and Foreign Travel questionnaire)	
Have you ever used any form of tobacco or any form of nicotine replacement therapy?... <input type="checkbox"/> Yes <input type="checkbox"/> No Date Stopped _____ month/year (If Yes, provide details in the Comments section.)			
PROPOSED INSURED BENEFICIARY (IF MORE SPACE IS NEEDED, USE THE COMMENTS SECTION)			
Primary Beneficiary	% of Proceeds	Date of Birth	Relationship to Proposed Insured
Contingent Beneficiary	% of Proceeds	Date of Birth	Relationship to Proposed Insured
OTHER PROPOSED INSURED (If Other Proposed Insured is age 0-17, complete the Juvenile Supplemental Application)			
Name (First, Middle Initial, Last)		Social Security Number	Gender at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (Street, City, State, ZIP)			Relationship to Proposed Insured
Primary Phone No.	Secondary Phone No.	E-mail	
Driver's License No. (If none, please explain)			Driver's License State
Occupation/Duties		Annual Income	Employer
Date of Birth	State of Birth (Country if not U.S.)	U.S. Citizen?... <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, complete the Foreign National and Foreign Travel questionnaire)	
Have you ever used any form of tobacco or any form of nicotine replacement therapy?... <input type="checkbox"/> Yes <input type="checkbox"/> No Date Stopped _____ month/year (If Yes, provide details in the Comments section.)			
OTHER PROPOSED INSURED BENEFICIARY (IF MORE SPACE IS NEEDED, USE THE COMMENTS SECTION)			
Primary Beneficiary	% of Proceeds	Date of Birth	Relationship to Insured
Contingent Beneficiary	% of Proceeds	Date of Birth	Relationship to Insured

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INDIVIDUAL LIFE INSURANCE APPLICATION PART 1, PAGE 2 OF 4



OWNER (Complete Policyowner Information if Proposed Insured is not the Policyowner)

Owner Is: Individual Employer Trust Other (Specify): _____

Name of Policyowner (First, Middle Initial, Last)	Relationship to Proposed Insured	Social Security No./Tax ID
Policyowner Address (Street, City, State, ZIP)		Date of Birth/Date of Trust
Policyowner Phone No.	Policyowner E-mail	

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

Name _____

Address _____

Street City State ZIP

PLAN INFORMATION

RISK/RATE CLASS APPLIED FOR:

Standard or Best Available Risk Class

Substandard Risk Class Proposed: Table _____

TERM LIFE PLAN AMOUNT OF INSURANCE APPLIED FOR: \$ _____

Product Selection	Optional Riders
<input type="checkbox"/> Term Life Answers (TLA) 10-Year Term Life	<input type="checkbox"/> Disability Waiver of Premium
<input type="checkbox"/> Term Life Answers (TLA) 15-Year Term Life	<input type="checkbox"/> Other Insured Rider: \$ _____
<input type="checkbox"/> Term Life Answers (TLA) 20-Year Term Life	<input type="checkbox"/> Dependent Children's Rider: \$ _____
<input type="checkbox"/> Term Life Answers (TLA) 30-Year Term Life	<input type="checkbox"/> Accidental Death Benefit Rider: \$ _____

UNIVERSAL LIFE PLAN AMOUNT OF INSURANCE APPLIED FOR: \$ _____

Product Selection	Death Benefit (pick one)	Optional Riders
<input type="checkbox"/> AccumUL Plus <input type="checkbox"/> AccumUL Answers <input type="checkbox"/> Income Advantage (IUL) <input type="checkbox"/> Life Protection Advantage (IUL)	<input type="checkbox"/> UL Option 1 Level Death Benefit	<input type="checkbox"/> Disability Waiver of Policy Charges <input type="checkbox"/> Disability Continuation of Planned Premium Rider: \$ _____ <input type="checkbox"/> Guaranteed Insurability Rider <input type="checkbox"/> Dependent Children's Rider: \$ _____ <input type="checkbox"/> Accidental Death Benefit Rider: \$ _____ <input type="checkbox"/> Additional Insured Term Rider (Self): \$ _____ <input type="checkbox"/> Additional Insured Term Rider (Other Insured): \$ _____
	<input type="checkbox"/> UL Option 2 Specified Amount plus Accumulation Value	
<input type="checkbox"/> Guaranteed Universal Life (GUL)	UL Option 1 Level Death Benefit	<input type="checkbox"/> Disability Waiver of Policy Charges <input type="checkbox"/> Disability Continuation of Planned Premium Rider: \$ _____ <input type="checkbox"/> Guaranteed Insurability Rider <input type="checkbox"/> Dependent Children's Rider: \$ _____ <input type="checkbox"/> Accidental Death Benefit Rider: \$ _____

PREMIUM INFORMATION

Premium Method	<input type="checkbox"/> Direct Bill <input type="checkbox"/> Bank Draft (Monthly Only) (Complete Payment Authorization Form) <input type="checkbox"/> Other (Please Explain) _____		
Frequency of Modal Premium	<input type="checkbox"/> Monthly (Bank Draft Only) <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly		
Modal Premium \$ _____		Proposed Insured	Other Proposed Insured
Collected Premium \$ _____	Date Policy to Save Age?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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INSURANCE HISTORY

1. Have you been offered cash, or any other consideration for obtaining this policy? Yes No
2. Are you planning to enter into a finance arrangement to pay any premium payments due under this policy? Yes No
3. Do you intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? Yes No
(If Yes to questions 1, 2 or 3, provide information in Comments section.)
4. In the past 12 months, have you applied for any life insurance or do you have any life insurance currently pending, excluding this application? Yes No
5. Do you have any existing life insurance or annuity contracts with the company or any other company? Yes No
6. Will this insurance replace or change any existing life insurance or annuity contract with the company or any other company? Yes No
(If Yes to questions 4, 5 or 6, complete the boxes below.)
The Producer shall comply with any additional state, and/or Company replacement requirements.

Person Proposed for Insurance	Company	Face Amount	Replaced/Converted?	Pending?	1035 Exchange?	Business or Personal	Year Issued
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

PROPOSED INSURED(S) HISTORY

1. Have you: (If answered Yes, please list details in the Comments section.)	Proposed Insured	Other Proposed Insured
(a) had life insurance coverage declined, postponed or limited, or been denied reinstatement or asked to pay extra premium by any insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) engaged in parachuting, hang gliding, rock or mountain climbing, skydiving, SCUBA diving, cliff diving, organized vehicle or boat racing, BASE or bungee jumping within the last three years or plan such activity in the next two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If Yes, complete the appropriate questionnaire.)		
(c) any intention of traveling or living outside the USA or Canada in the next two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If Yes, complete the Foreign National and Foreign Travel questionnaire.)		
(d) flown as a civilian pilot, student pilot or crew member within the last three years or plan such activity in the next two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If Yes, complete the Aviation questionnaire.)		
(e) within the last five years been convicted of two or more moving violations, been convicted of driving under the influence of alcohol or drugs or had a driver's license suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) been convicted of or currently awaiting trial for a felony, or have been incarcerated within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

COMMENTS

Provide any additional information necessary and the details of Yes answers. Identify the question number if applicable. Use an additional sheet of paper if necessary.

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FINANCES (COMPLETE EITHER THE PERSONAL OR BUSINESS SECTION)

Personal:

- Purpose of Insurance:
 - Income Replacement
 - Debt Repayment
 - Estate Conservation
 - Other (Specify): _____
- Personal Finances: Gross Annual Income \$ _____ Total Assets \$ _____ Total Liabilities \$ _____
- Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? . . . Yes No
 If Yes, please explain and provide the filing and discharge dates _____

Business: Please attach a copy of your Company's latest financial statements (Balance Sheet and Profit and Loss). If not available, complete the following questions:

- Purpose of Insurance:
 - Buy-Sell: Type of Agreement: Entity/Stock Redemption Cross Purchase Wait-and-See
 - Key Person: Explanation of special skills/relationships to the business _____
 - Other: Please Explain _____
- Proposed Insured's Salary (include bonus) \$ _____
- Company Book Value \$ _____ Company Market Value \$ _____
 Proposed Insured's % Ownership \$ _____ Market Value of Proposed Insured's Ownership \$ _____
- Business Insurance Carried by Other Owners, Officers, Partners or Key Persons:

Name	Title and Interest	Amounts Now Carried and Company	Amount Now Applied For and Company

- Within the past 5 years, has the business filed for bankruptcy or had any judgments or liens filed against it? . . . Yes No
 If Yes, please explain and provide filing and discharge dates _____

AGREEMENT

Agreement: I represent the information above is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy effective the issue date. Unless otherwise provided under a temporary insurance agreement, I understand that no insurance shall take effect until all outstanding application requirements have been received, a policy is issued and the first premium is received by United of Omaha during the Proposed Insured's lifetime. The issue date of the policy will be the date shown on the policy, even though coverage may not become effective until a later date. You must immediately notify United of Omaha if there has been a change in the Proposed Insured's health or habits that will change any statement or answer to any question in the application as of the date the policy is delivered. No policy of any kind will be in effect if the Proposed Insured dies or is otherwise ineligible for the insurance for which they applied. No producer can waive or change any receipt or policy provision or agree to issue any policy.

This application includes Part 1, Part 2 and/or the Statements to Examiner as well as all approved supplemental forms or amendments the Insurer specifically designates as parts of the application, by attaching as part of any policy delivered to the Owner.

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.

Signed at: _____ Date _____
 City State Mo Day Yr

Signature of Proposed Insured Age 15 and Over	Signature of Applicant/Owner/Trustee if other than Proposed Insured or if the Owner is a corporation, trust, or other entity. Include title of Signee(s).
Signature of Other Proposed Insured Age 15 and Over	Signature of Applicant/Owner/Trustee if other than Other Proposed Insured or if the Owner is a corporation, trust, or other entity. Include title of Signee(s).
Signature of Parent or Guardian if Proposed Insured is under Age 15	

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3300 Mutual of Omaha Plaza, Omaha, NE 68175



INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 1 OF 3

PROPOSED INSURED(S) INFORMATION				
Name of Proposed Insured _____		Name of Other Proposed Insured _____		
Date of Birth _____		Date of Birth _____		
Height _____ ft. _____ in. Weight _____ lbs.		Height _____ ft. _____ in. Weight _____ lbs.		
PHYSICIAN INFORMATION				
Person Proposed for Insurance	Name, Address and Telephone Number of Personal Physician	Date Last Seen	State Reason, Findings and Treatment	
FAMILY HISTORY				
Do you have a deceased parent(s) and/or sibling(s)?			Proposed Insured	Other Proposed Insured
(If Yes, please list details below. If more space is needed, use the Comments section.)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Age at Death	Cause of Death	Age at Death	Cause of Death
	Proposed Insured	Proposed Insured	Other Proposed Insured	Other Proposed Insured
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				
MEDICAL HISTORY				
1. Have you ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?			Proposed Insured	Other Proposed Insured
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:				
(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, pacemaker or defibrillator, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, sleep apnea or shortness of breath?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) any disease, or disorder of vision, or hearing?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/metabolic disorder?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 2 OF 3

MEDICAL HISTORY CONTINUED

<p>3. In the past 10 years, have you:</p> <p>(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a member of the medical profession?</p> <p>(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?</p> <p>(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous? .</p>	<p>Proposed Insured</p>	<p>Other Proposed Insured</p>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. In the past 12 months, have you:</p> <p>(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?</p> <p>(b) received, or been advised by a member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy? .</p> <p>(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?</p> <p>(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?</p> <p>(e) had an unexplained weight loss of greater than 10 pounds (other than due to diet or exercise)? .</p>	<p>Proposed Insured</p>	<p>Other Proposed Insured</p>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. In the past two years, have you (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication?</p> <p>(If Yes, please list details below. If more space is needed use the Comments section.)</p>	<p>Proposed Insured</p>	<p>Other Proposed Insured</p>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Person Proposed for Insurance	Medication Name (copy from pharmacy label)	Date Last Taken	Prescribing Physician (if any)	Reason	Dosage/Frequency

<p>6. In the past five years, have you consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition?</p> <p>(If Yes, please list details below. If more space is needed use the Comments section.)</p>	<p>Proposed Insured</p>	<p>Other Proposed Insured</p>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Person Proposed for Insurance	Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

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INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 3 OF 3

COMMENTS

List details of Yes answers. Identify question number: Include diagnosis, dates, prescription medications, duration, and names and addresses of all attending physicians and medical facilities. Use an additional sheet of paper if necessary.

AGREEMENT

I represent the information in this application is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy effective the issue date.

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.

Signed at: _____ Date _____
City State Mo Day Yr

Signature of Proposed Insured Age 15 and Over Signature of Parent or Guardian if Proposed Insured is under Age 15

Signature of Other Proposed Insured Age 15 and Over

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PRODUCER STATEMENT

1. Has any person proposed for insurance informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? Yes No

If "Yes," give name(s) of the person(s) _____

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

3. Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer's Guide and comply with all state and Company replacement requirements? Yes No If "No," please explain _____

4. 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

If "No," please explain _____

5. I conducted said interview in person Yes No If "No," please explain _____

Signature of Producer # 1 Production Number Mo Day Yr

Signature of Producer # 2 Production Number Mo Day Yr

Print or Stamp Producer #1 Name

Print or Stamp Producer #2 Name

General Agent/General Manager Name General Agent/General Manager Stamp

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Producer's Report

(Must be completed by the Producer who obtained the application on the Proposed Primary Insured named below.)

1 Is Proposed Primary Insured self-supporting? Yes No

If "No," provide the following information about the person on whom Proposed Primary Insured is dependent:

Full Name _____ Address _____ Birth Date _____

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

2 If Proposed Primary Insured used a different name in past, give previous different full name(s) _____

3 Are you related to the Proposed Primary Insured or Owner? Yes No If answered "Yes," state relationship _____

4 How long have you known the Proposed Primary Insured? _____

5 How long have you known the Proposed Owner? _____

6 Have you, the producer, observed or are you aware of any additional information that may affect the issuance of this policy?

If "Yes," explain below Yes No

7 Will any entity other than a life insurance company evaluate the Proposed Life Insured(s) medically to determine life expectancy or to otherwise obtain financing? Yes No If "Yes," provide details _____

8 Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? Yes No

9 Rate class quoted _____

10 Please check the Underwriting requirements ordered: Blood Profile/HOS Inspection Report MD Exam
 Treadmill EKG EKG Paramedical Exam Paramed Company _____

11 Previous residence(s) of Proposed Primary Insured for past five years.

Address	From	To

Additional Comments



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

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)

Memo _____	Signed By: _____
<div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;">Bank Routing Number</div>	<div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;">Bank Account Number</div>
<div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;">Check Number (if shown at bottom, may be shown before or after the account #)</div>	

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



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: _____

Signature of Proposed Insured

Date: _____
Mo Day Yr

Signature of Spouse (if Proposed Insured)

Date: _____
Mo Day Yr

Signature of Parent or Guardian (if Proposed Insured is a Minor)

Date: _____
Mo Day Yr

Signature of Non-minor Child (if Proposed Insured is a Non-minor)

Date: _____
Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS



TEMPORARY LIFE INSURANCE AGREEMENT (“AGREEMENT”)

United of Omaha Life Insurance Company (“United”, “we”, “our”, “us”), Mutual of Omaha Plaza, Omaha, NE 68175

IF ANY PROPOSED INSURED DIES WHILE COVERAGE UNDER THIS AGREEMENT IS IN EFFECT, WE WILL PAY TO THE BENEFICIARY(IES) NAMED IN THE APPLICATION THE TEMPORARY INSURANCE BENEFIT (“TIA BENEFIT”) DESCRIBED IN THE SECTION BELOW ENTITLED “BENEFIT”.

QUESTIONS	IF ANY QUESTION LISTED BELOW IS ANSWERED “YES” OR LEFT BLANK, NO COVERAGE WILL TAKE EFFECT UNDER THIS AGREEMENT.	
	The questions below apply to all Proposed Insured(s) shown on the application.	
		YES NO
	1	Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, had surgery performed or recommended, or been advised by a member of the medical profession to be admitted or to have a diagnostic test other than an HIV test? <input type="checkbox"/> <input type="checkbox"/>
	2	Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider? <input type="checkbox"/> <input type="checkbox"/>
	3	Has any Proposed Insured ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?..... <input type="checkbox"/> <input type="checkbox"/>
	4	Is any Proposed Insured under 15 days old or over 70 years of age?..... <input type="checkbox"/> <input type="checkbox"/>
5	Does amount applied for exceed \$1,000,000? <input type="checkbox"/> <input type="checkbox"/>	
6	Is the policy applied for a second to die life insurance policy? <input type="checkbox"/> <input type="checkbox"/>	

NO COVERAGE	THERE IS NO TEMPORARY INSURANCE COVERAGE IF:
	1 No premium is submitted at the time this Agreement is submitted or if the premium check or electronic transaction is not honored; or
	2 Any question listed above is answered “Yes” or left blank; or
	3 There is a material misrepresentation in any answer to any question listed above or to any questions or statements in the application and/or any questionnaires and supplements to the application; or
	4 Internal Revenue Code section 1035 exchange paperwork is received without full initial modal premium; or
5 A Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, in which case, United will not be liable under this Agreement except to return any payment paid with the application.	

BENEFIT	For purposes of this Agreement, the TIA Benefit is an amount equal to the lesser of: (1) the amount of insurance applied for in the application; or (2) \$1,000,000 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 TIA Benefit under this Agreement exceed \$1,000,000.
----------------	--

START DATE	Any Temporary insurance coverage provided STARTS on the date all of the following requirements have been met:
	1 This Agreement has been fully completed, signed and dated on the date of the application by the Proposed Insured(s), Applicant/Owner and Producer.
	2 The full initial modal premium is received at our Home Office and made by check or authorized electronic transaction. A payment will be considered to be received only if one of the following valid items is received at our Home Office: (a) a check made payable to United of Omaha in the amount of the full first required premium; or (b) a completed and signed electronic transaction authorization for the first full premium.
	3 All application information (including, but not limited to, all information necessary to complete the application and/or any questionnaires and supplements to the application) and any medical exam and tests required by United are completed. Notwithstanding the preceding sentence, if the Proposed Insured dies within 30 days after the date this Agreement is signed as a direct result of, independent from all other causes, accidental bodily injury that occurs after the date of this Agreement but before any medical exam and tests are completed, we will pay to the beneficiary(ies) named in the application the TIA Benefit.

END DATE	This Agreement and any coverage provided hereunder will END on the earliest of the following dates:
	1 90 days from the date of this Agreement; 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 a standard risk class; or (b) have declined to issue you a policy; or (c) will not provide temporary insurance coverage; or
	4 The date the applicant/owner withdraws the application for insurance.

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement limit or waive any rights under any life insurance policy issued. If 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 Agreement 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 Agreement.

SIGNATURES	Signature of Proposed Insured _____ Date _____
	Signature of Other Proposed Insured _____ Date _____
	Signature of Applicant/Owner (if other than Proposed Insured) _____ Date _____
	Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> Amount remitted/authorized \$ _____
	I/We have not received a check with the application if any question in the above section entitled “Questions” was answered “yes” or left blank. I/We agree that I/We am/are not authorized to change or waive the terms of this Agreement and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Agreement 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 any accelerated death benefit rider may be taxable. Receipt of the 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 an accelerated death benefit.

DISCLOSURE FOR TERM LIFE INSURANCE POLICIES

If you are applying for term life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness 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 charge for the rider.

BENEFIT DESCRIPTION

If the Insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit up to \$1,000,000 or 80% of the policy's death benefit, whichever is less. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a \$100 charge. The actuarial discount rate will not be greater than 6%.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay the accelerated death benefit, the policy will continue with a reduced face amount and a reduced premium.

DISCLOSURE FOR UNIVERSAL LIFE INSURANCE POLICIES

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider, the Accelerated Death Benefit for Chronic Illness Rider, and their effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the riders. There is no premium or cost of insurance for these riders.

BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit. The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of \$1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

Acknowledgment

I acknowledge receipt of this Disclosure Form



Applicant/Owner Signature

Date

I have provided this Disclosure Form to the Applicant



Producer Signature

Date

A Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a \$100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount rate will not be greater than 6%.

BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats and safety due to severe cognitive impairments.

The sum of all requested accelerations may not exceed the lesser of \$1,000,000 or 80% of the specified amount as of the date of the first requested acceleration. Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by an actuarial discount rate multiplied by the insured's life expectancy in years, a \$100 charge, and the pro-rated amount of any outstanding loans.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay any accelerated death benefit, the following will occur: (a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the death benefit; and (b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.

HIV Test Informed Consent Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company



In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Pre-Testing Consideration

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

Test Results

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider. HIV test results are highly reliable but not 100% accurate. If the test gives a positive result, you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

OTHER SOURCES OF INFORMATION

For more added information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

Disclosure of Test Results

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results. The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law release positive test results, except as provided below.

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released. If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

Consent for HIV Testing

I have read and I understand this HIV test Informed consent form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications as appropriate, within this 90 (ninety) day period.

In the event of a positive test result:

Send the result to me at: Address: _____

I authorize (name of insurer) to send the result to another person: _____

Name: _____

Address: _____

I authorize (name of insurer) to send the result to the following physician or health care provider:

Physician's Name: _____

Address: _____ Authorization _____

Name of Applicant _____

Signature of Applicant _____ Date _____

Signature of legal guardian, if any _____ Date _____

Signature of Person obtaining consent _____ Date _____

PLEASE SUBMIT

MLU17427_1208

IMPORTANT DOCUMENTS

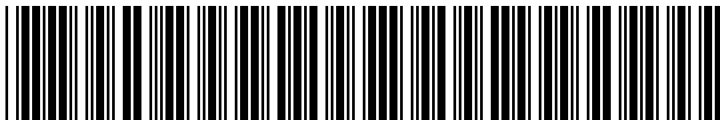
LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

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). **However, do not provide the TIA to the client if a check or electronic transaction for the initial premium was not collected at the time of application.**



HIV Test Informed Consent Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company



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Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

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If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released. If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

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In the event of a positive test result:

Send the result to me at: Address: _____

I authorize (name of insurer) to send the result to another person: _____

Name: _____

Address: _____

I authorize (name of insurer) to send the result to the following physician or health care provider:

Physician's Name: _____

Address: _____ Authorization _____

Name of Applicant _____

Signature of Applicant _____ Date _____

Signature of legal guardian, if any _____ Date _____

Signature of Person obtaining consent _____ Date _____

TEMPORARY LIFE INSURANCE AGREEMENT (“AGREEMENT”)

United of Omaha Life Insurance Company (“United”, “we”, “our”, “us”), Mutual of Omaha Plaza, Omaha, NE 68175

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QUESTIONS	IF ANY QUESTION LISTED BELOW IS ANSWERED “YES” OR LEFT BLANK, NO COVERAGE WILL TAKE EFFECT UNDER THIS AGREEMENT.	
	The questions below apply to all Proposed Insured(s) shown on the application.	
		YES NO
	1	Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, had surgery performed or recommended, or been advised by a member of the medical profession to be admitted or to have a diagnostic test other than an HIV test? <input type="checkbox"/> <input type="checkbox"/>
	2	Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider? <input type="checkbox"/> <input type="checkbox"/>
	3	Has any Proposed Insured ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?..... <input type="checkbox"/> <input type="checkbox"/>
	4	Is any Proposed Insured under 15 days old or over 70 years of age?..... <input type="checkbox"/> <input type="checkbox"/>
5	Does amount applied for exceed \$1,000,000? <input type="checkbox"/> <input type="checkbox"/>	
6	Is the policy applied for a second to die life insurance policy? <input type="checkbox"/> <input type="checkbox"/>	

NO COVERAGE	THERE IS NO TEMPORARY INSURANCE COVERAGE IF:
	1 No premium is submitted at the time this Agreement is submitted or if the premium check or electronic transaction is not honored; or
	2 Any question listed above is answered “Yes” or left blank; or
	3 There is a material misrepresentation in any answer to any question listed above or to any questions or statements in the application and/or any questionnaires and supplements to the application; or
	4 Internal Revenue Code section 1035 exchange paperwork is received without full initial modal premium; or
5 A Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, in which case, United will not be liable under this Agreement except to return any payment paid with the application.	

BENEFIT	For purposes of this Agreement, the TIA Benefit is an amount equal to the lesser of: (1) the amount of insurance applied for in the application; or (2) \$1,000,000 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 TIA Benefit under this Agreement exceed \$1,000,000.
----------------	--

START DATE	Any Temporary insurance coverage provided STARTS on the date all of the following requirements have been met:
	1 This Agreement has been fully completed, signed and dated on the date of the application by the Proposed Insured(s), Applicant/Owner and Producer.
	2 The full initial modal premium is received at our Home Office and made by check or authorized electronic transaction. A payment will be considered to be received only if one of the following valid items is received at our Home Office: (a) a check made payable to United of Omaha in the amount of the full first required premium; or (b) a completed and signed electronic transaction authorization for the first full premium.
	3 All application information (including, but not limited to, all information necessary to complete the application and/or any questionnaires and supplements to the application) and any medical exam and tests required by United are completed. Notwithstanding the preceding sentence, if the Proposed Insured dies within 30 days after the date this Agreement is signed as a direct result of, independent from all other causes, accidental bodily injury that occurs after the date of this Agreement but before any medical exam and tests are completed, we will pay to the beneficiary(ies) named in the application the TIA Benefit.

END DATE	This Agreement and any coverage provided hereunder will END on the earliest of the following dates:
	1 90 days from the date of this Agreement; 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 a standard risk class; or (b) have declined to issue you a policy; or (c) will not provide temporary insurance coverage; or
	4 The date the applicant/owner withdraws the application for insurance.

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement limit or waive any rights under any life insurance policy issued. If 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 Agreement 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 Agreement.

SIGNATURES	_____ Signature of Proposed Insured	_____ Date
	_____ Signature of Other Proposed Insured	_____ Date
	_____ Signature of Applicant/Owner (if other than Proposed Insured)	_____ Date
	Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> Amount remitted/authorized \$ _____	
	I/We have not received a check with the application if any question in the above section entitled “Questions” was answered “yes” or left blank. I/We agree that I/We am/are not authorized to change or waive the terms of this Agreement and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Agreement 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

A MUTUAL of OMAHA COMPANY



ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefit received under any accelerated death benefit rider may be taxable. Receipt of the 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 an accelerated death benefit.

DISCLOSURE FOR TERM LIFE INSURANCE POLICIES

If you are applying for term life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness 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 charge for the rider.

BENEFIT DESCRIPTION

If the Insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit up to \$1,000,000 or 80% of the policy's death benefit, whichever is less. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a \$100 charge. The actuarial discount rate will not be greater than 6%.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay the accelerated death benefit, the policy will continue with a reduced face amount and a reduced premium.

DISCLOSURE FOR UNIVERSAL LIFE INSURANCE POLICIES

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider, the Accelerated Death Benefit for Chronic Illness Rider, and their effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the riders. There is no premium or cost of insurance for these riders.

BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit. The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of \$1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

Acknowledgment

I acknowledge receipt of this Disclosure Form



Applicant/Owner Signature

Date

I have provided this Disclosure Form to the Applicant



Producer Signature

Date

A Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a \$100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount rate will not be greater than 6%.

BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats and safety due to severe cognitive impairments.

The sum of all requested accelerations may not exceed the lesser of \$1,000,000 or 80% of the specified amount as of the date of the first requested acceleration. Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by an actuarial discount rate multiplied by the insured's life expectancy in years, a \$100 charge, and the pro-rated amount of any outstanding loans.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay any accelerated death benefit, the following will occur: (a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the death benefit; and (b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.

United of Omaha Life Insurance Company - MIB Group, 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, 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 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. 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 is: 50 Braintree Hill Park, Suite 400, Boston, 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 may be obtained on its website at www.mib.com.

Investigative Consumer Reports Notice

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 inform you whether an investigative consumer report was requested, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

If you request any additional disclosures from either Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company, please send your request to the following address: Attention: Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, NE 68175. Following this Notice is a written Summary of Your Rights under Section 609(c) of the Fair Credit Reporting Act, as amended.

United of Omaha Life Insurance - 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. 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





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 checkwriting 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 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 1700 G Street NW Washington, DC 20552 b. Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations and federal branches and federal agencies of foreign bank 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 c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center PO Box 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut St., Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. 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 United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive 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: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357



FIT TEST

Name: _____

Date: _____

Complete with ALL Fully Underwritten Term and UL Applications

Requirements

- Ages 18-75
- Minimum face amount: \$100,000
- Maximum face amount: \$5,000,000 Total coverage in force and applied for with United of Omaha and Companion Life Insurance companies
- Nontobacco users
- Base rating *after* normal credits of table 4 or less
- Does not apply to “flat extra” ratings or those with CAD prior to age 50 or Type I Diabetes, or ratable substance abuse, stroke or cancer histories

If your client has several of the following characteristics they may qualify for up to an *additional two table credits* from the base rating on both fully underwritten term and permanent insurance.

Note: No more than two lifestyle characteristics can be applied toward credits

3 Characteristics = 1 table credit 5 Characteristics = 2 table credits

Lifestyle Characteristics

Check all that apply

- Regular preventative medical care and compliant follow-up for treated impairments within past 12 months? **Yes**
- No tobacco use for past 10 years? **Yes**
- Income > \$100,000 or net worth > \$1,000,000?..... **Yes**
- Preferred or better driving record?..... **Yes**

Medical Characteristics

- Great family history – no deaths from any disease prior to age 70? **Yes**
- Cholesterol/HDL ratio under 5.0? **Yes**
- A1c test < 5.7? **Yes**
- Serum albumin > 4.2 ages 61-75? **Yes**
- Negative cardiac testing: GXT, non-imaged or imaged (stress echo, perfusion study), echocardiogram, EBCT or angiography (within the past 2 years)? **Yes**
- GXT exercise performance over 10 METS (within the past 2 years)? **Yes**
- Optimal blood pressure control-treated or untreated with average of 135/85 or better? **Yes**
- Preferred or better build, ages 18-60. Standard plus or better build, ages 61-75?..... **Yes**
- BNP <100 ages 61-75? **Yes**
- Normal CBC ages 61-75? **Yes**

If you answered yes to 3 or more of these questions, you may qualify for additional table credits.

Submit with Application

(July 2017)

Department of the Treasury
Internal Revenue Service

▶ **Request may not be processed if the form is incomplete or illegible.**
▶ **For more information about Form 4506T-EZ, visit www.irs.gov/form4506tez.**

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number or individual taxpayer identification number on tax return
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Third party name Mutual of Omaha Insurance Company c/o NCS/TRV Processing	Telephone number 1-800-582-7066
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Address (including apt., room, or suite no.), city, state, and ZIP code

P.O. Box 321, Egg Harbor City, NJ 08215

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in line 6 before signing. Sign and date the form once you have filled in this line. Completing this step helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Year(s) requested.** Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

Note. If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS will notify you or the third party that it was unable to locate a return, or that a return was not filed, whichever is applicable.

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** spouse must sign. **Note:** This form must be received by IRS within 120 days of the signature date.

Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.

Sign Here	▶ Signature (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
	▶ Spouse's signature	Date	

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form 4506T-EZ, such as legislation enacted after it was published, go to www.irs.gov/form4506tez.

Caution. Do not sign this form unless all applicable lines have been completed.

Purpose of form. Individuals can use Form 4506T-EZ to request a tax return transcript for the current and the prior three years that includes most lines of the original tax return. The tax return transcript will not show payments, penalty assessments, or adjustments made to the originally filed return. You can also designate (on line 5) a third party (such as a mortgage company) to receive a transcript. Form 4506T-EZ cannot be used by taxpayers who file Form 1040 based on a tax year beginning in one calendar year and ending in the following year (fiscal tax year). Taxpayers using a fiscal tax year must file Form 4506-T, Request for Transcript of Tax Return, to request a return transcript.

Use Form 4506-T to request tax return transcripts, tax account information, W-2 information, 1099 information, verification of non-filing, and record of account.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get Transcript of Your Tax Records" under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506T-EZ to the address below for the state you lived in when the return was filed.

If you are requesting more than one transcript or other product and the chart below shows two different addresses, send your request to the address based on the address of your most recent return.

If you filed an individual return and lived in:

Alabama, Kentucky, Louisiana, Mississippi, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address

Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Washington, Wisconsin, Wyoming

Connecticut, Delaware, District of Columbia, Florida, Georgia, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia

Mail or fax to the "Internal Revenue Service" at:

RAIVS Team
Stop 6716 AUSC
Austin, TX 73301
855-587-9604

RAIVS Team
Stop 37106
Fresno, CA 93888
(855) 800-8105

RAIVS Team
Stop 6705 P-6
Kansas City, MO 64999
855-821-0094

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note. If the address on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address.

Signature and date. Form 4506T-EZ must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506T-EZ within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked

Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506T-EZ exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. If you request a transcript, sections 6103 and 6109 require you to provide this information, including your SSN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506T-EZ will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form**, 9 min.; **Preparing the form**, 18 min.; and **Copying, assembling, and sending the form to the IRS**, 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506T-EZ simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.

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?



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
3. If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months? 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 agent 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

Agent's Signature _____ Agent'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.)

Applicant/Owner's Copy

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
3. If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months? 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 agent 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

Agent's Signature _____ Agent'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.)



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.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



CHILDREN'S RIDER LIFE INSURANCE SUPPLEMENTAL APPLICATION

THE BENEFICIARY FOR THE DEPENDENT CHILDREN'S RIDER WILL BE THE PROPOSED INSURED OR AS OTHERWISE SET FORTH IN THE RIDER.

Have any of the Dependent Children proposed for insurance received medical care for or been diagnosed by a member of the medical profession for:

(a) a heart or circulatory disease? Yes No (b) a birth defect or mental abnormality? . . Yes No

(c) juvenile diabetes or any form of cancer? Yes No

(d) any other chronic illness or condition which requires periodic medical care within the past 3 years? Yes No

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

DEPENDENT CHILDREN(S) UNDERWRITING INFORMATION

If more space is needed to provide Dependent Children information, attach separate sheet if necessary.

1 Child #1 _____
First Name Initial Last Name

Age _____ Male Female Birth Date _____
Mo Day Yr

Social Security Number _____ Relationship to Proposed Insured _____

2 Child #2 _____
First Name Initial Last Name

Age _____ Male Female Birth Date _____
Mo Day Yr

Social Security Number _____ Relationship to Proposed Insured _____

3 Child #3 _____
First Name Initial Last Name

Age _____ Male Female Birth Date _____
Mo Day Yr

Social Security Number _____ Relationship to Proposed Insured _____

4 Child #4 _____
First Name Initial Last Name

Age _____ Male Female Birth Date _____
Mo Day Yr

Social Security Number _____ Relationship to Proposed Insured _____

ICC09L033A

PLEASE SUBMIT

L8252

