



# TERM LIFE

**Regular Mail:**

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

**FAX Number: 317-692-7711****Telephone: 800-428-3001****Overnight Mail:**

(FedEx or UPS Recommended)  
United Home Life Insurance Company  
225 South East St.  
Indianapolis, IN 46202

\_\_\_\_\_ # pages including cover

**Fax only once.**

Agent Name: \_\_\_\_\_ Agent #: \_\_\_\_\_

Agent Phone: \_\_\_\_\_ Agent Fax: \_\_\_\_\_

Agent Email Address: \_\_\_\_\_

How do you prefer to be notified if we should need any underwriting requirements?

E-Mail  Fax

**Proposed Insured's Name:** \_\_\_\_\_

Do you personally know the Proposed Insured?  Yes  No

Have you written insurance on the Proposed Insured in the past three (3) years?  Yes  No

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

If No, how was the application taken?

Solicited by:  Mail  Phone  Internet  Fax  Other \_\_\_\_\_  
(Explain)

Did you identify any unusual behavior or suspicious activity by the Owner or Proposed Insured?  Yes  No

If Yes, please explain. \_\_\_\_\_

**Special Instructions you want us to know:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MAIL POLICY TO:**  Owner  Agent

**Personal History Interviews (PHIs):**

**Option 1 (preferred option) Know Before You Go®:** You, the agent, initiate a point-of-sale (POS) interview from your client's home by calling **866-333-6557**. Tell the operator this interview is for UHL and the Simple Term 20, Simple Term 30, Simple Term 20 ROP, or Simple Term 20 DLX plan and hand the phone to your client (**Be specific as to which product you want so that only the plan-specific questions will be asked**). During the call, the interviewer will conduct MIB and Prescription Drug searches to better determine your client's suitability for the product you've selected. Upon completion of the interview, and based on the client's answers to the questions and results of the database searches, the interviewer will tell you whether or not the application should be sent to the Home Office.

**Did you complete a point-of-sale Personal History Interview with your client?  Yes  No**

**Option 2:** UHL will order the PHI after you've completed the application with your client and submitted it to the Home Office. A PHI is required for all Simple Term 20, Simple Term 30, Simple Term 20 ROP, and Simple Term 20 DLX sales, regardless of face amount. What is the best time to reach this client?

Home Phone (\_\_\_\_) \_\_\_\_\_ available days?  Yes  No

Business Phone (\_\_\_\_) \_\_\_\_\_ available days?  Yes  No

Cell Phone (\_\_\_\_) \_\_\_\_\_ available days?  Yes  No

**If a language other than English is required, please specify \_\_\_\_\_.**

**Important Reminders**

- 1. UHL TERM PRODUCTS USE THE "AGE LAST BIRTHDAY" METHOD FOR DETERMINING THE AGE OF THE PROPOSED INSURED FOR INSURANCE PURPOSES.**
- 2. Simple Term 30 Issue Ages: Male and Female 20-45**
3. Print legibly in English.
4. Keep original app until policy is issued.
5. If faxing, keep fax confirmation message that fax was successful.
6. If the replacement question is answered "Yes," ensure that the applicable replacement form(s) has been completed and included (if required).
7. Cash is not permitted for the payment of premium(s).
8. The Fair Credit Reporting Act/MIB Notice and, if applicable, the Notice of Insurance Information Practices must be provided to the Proposed Insured. These documents must also be provided to any applicant who completes the Know Before You Go® (point-of-sale) PHI process, regardless of whether an application is written or not. If applicable, the Notice of Insurance Information Practices must also be provided to the Owner.
9. If requesting an agent commission split because of multiple writing agents, please indicate each agent's name, agent code, and the commission split percentage in the Special Instructions section. At least one writing agent is required to sign the application.
- 10. Appointment regulations vary by state. A few states require appointment before an application can be taken; several others require appointment within a period of days after an application is written. Contact the Home Office or check with your state to ensure compliance prior to taking an application.**

# Term Life Insurance Application

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

## SECTION 1 – Proposed Insured

Last Name		First Name		Middle Initial
Date of Birth (M-D-Y)	State of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status	Height	Weight		
Social Security Number	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, give immigration status/type of visa:</i>			
Street Address (Physical street address, not a P.O. Box)				
City		State	Zip Code	
Phone Number ( )		Email Address		
Billing Address (Owner's P.O. Box if applicable)		City	State	Zip Code
Secondary Addressee/ Third Party (For Past Due Notices)	Name	Street Address		
City		State	Zip Code	
Employer/Occupation/Duties/How Long There (Required)				

## SECTION 2 – Ownership (Complete only if Owner is other than Proposed Insured)

Owner Name		Relationship	Social Security Number	
Owner Street Address (Physical street address, not a P.O. Box)			City	
State	Zip Code	Owner Email Address		
Contingent Owner Name		Relationship	Social Security Number	

## SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name			Relationship
Age	Date of Birth (M-D-Y)	Social Security Number	Share %
Primary Beneficiary Name			Relationship
Age	Date of Birth (M-D-Y)	Social Security Number	Share %
Contingent Beneficiary Name			Relationship
Age	Date of Birth (M-D-Y)	Social Security Number	Share %

## SECTION 4 – Plan of Insurance

Plan of Insurance <input type="checkbox"/> Simple Term 20 <input type="checkbox"/> Simple Term 30 <input type="checkbox"/> Simple Term 20 ROP <input type="checkbox"/> Simple Term 20 DLX <input type="checkbox"/> Check here if you are willing to accept any product listed in this section for which you qualify based on this application. The insurance for which you qualify may have a face amount less than any indicated on this application and riders may not be available. All premiums will be applied toward the insurance for which you qualify. No change in amount, plan of insurance, or benefits will be effective unless agreed to in writing by the applicant.	Face Amount: \$ _____
<input type="checkbox"/> Accidental Death Benefit (not available with Simple Term 20 ROP) \$ _____	
<input type="checkbox"/> Waiver of Premium (not available with Simple Term 20 ROP or Simple Term 20 DLX)	

## SECTION 5 – Payment Information

Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly EFT* Modal Premium Amount \$ _____ \$ _____ paid with application. <b>*If selected, complete EFT authorization form.</b>
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**SECTION 6 – Other Insurance**

Do you have any existing life insurance policies or annuity contracts?  Yes  No

If "Yes," please complete any necessary replacement forms.

**SECTION 7 – Stranger Owned Life Insurance**

Is there, or will there be, any agreement or understanding that provides for a party, other than the Owner, to obtain any interest in any policy issued on the life of the Proposed Insured as a result of this application?  Yes  No

**SECTION 8 – Nicotine Use**

Has the Proposed Insured used nicotine in any form in the past 12 months?  Yes  No

**SECTION 9 – Physician Information**

Name of Family Physician (Required)

Family Physician Phone Number (Required)

( ) -

Family Physician Address (Required)

**SECTION 10 – Medical Questions**

**PART A – SIMPLE TERM 20 DLX – COMPLETE PART A ONLY**

If any question in Part A is answered "Yes", the Proposed Insured is not eligible for any plan of insurance.

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been told that you need an organ transplant or have you been diagnosed as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Do you require assistance to feed, bathe, dress, or take your own medication or are you currently confined to a hospital, nursing home, mental facility, hospice, or require home health nursing care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. <b>In the past twelve (12) months:</b>	
1. Have you been hospitalized two or more times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you used any illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. <b>In the past 5 years:</b>	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer's Disease or Dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension) or Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Sickle Cell Anemia or Kidney Disease (including dialysis, nephropathy) or Liver Disease (including hepatitis B & C)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. ALS (Lou Gehrig's Disease) or Neurological disorders (including neuropathy, excluding controlled seizure disorder with no seizures in the past 2 years)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been advised by a medical professional to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been treated for or been advised to have treatment for alcohol or drug dependency or consumed more than 10 alcoholic drinks per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. <b>In the past 10 years</b> have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART B – ALL OTHER TERM PLANS – COMPLETE PARTS A & B**

If any question in Part B is answered "Yes", the Proposed Insured is not eligible for any term plans in Part B. Submit the case as Simple Term 20 DLX.

A. <b>In the past 2 years</b> have you been declined or postponed for Life Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. <b>In the past 5 years:</b>	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes requiring insulin treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. SLE (Systemic Lupus Erythematosus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Have you ever been diagnosed as being disabled, or been diagnosed as disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Do you now participate in, or do you have plans to participate in scuba diving, sky diving, hang-gliding, mountain climbing, rock climbing, any form of motorized racing, or any type of flying as a pilot or crew member?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION 11 – Agreement/Acknowledgment

I hereby apply for the insurance indicated above and I am submitting the first premium. I have read (or have had read to me) all statements and answers recorded on this application, and I certify that the answers are true and accurate to the best of my knowledge and belief whether written by my own hand or not. I understand and agree that no information or knowledge obtained by any agent, medical examiner, or any other person in connection with this application shall be construed as having been made known to or binding upon United Home Life Insurance Company unless such information is in writing and made a part of this application. I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

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

**\*\*\*WARNING\*\*\***

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

I hereby certify under penalties of perjury, that the tax identification number provided is true, correct, and complete.

## SECTION 12 – Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, or other medical or medically related facility, electronic health record provider, medical information retrieval service, insurance company, MIB, Inc. ("MIB"), or other organization, institution, or person, that has any records or knowledge of me or my dependents, if they are to be insured, or our health, to give the United Home Life Insurance Company ("UHL") or its reinsurer(s) any such information. UHL may also disclose such information to reinsurers, MIB, persons or entities performing business, professional, or insurance functions for UHL or as may otherwise be legally allowed. I further authorize UHL or its reinsurer(s) to make a brief report of my personal health information to MIB. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information.

I understand that UHL may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date of my signature below. I have a right to receive a copy of this authorization.

## SECTION 13 – HIPAA Authorization

### This authorization complies with the HIPAA Privacy Rule.

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company and its agents, employees, and representatives. United Home Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Home Life Insurance Company or as may otherwise be legally allowed. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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

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

This authorization shall remain in force for 24 months following the date of my signature below, and a copy, image, or facsimile of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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

## SECTION 14 – Disclosure Acknowledgement

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

## SECTION 15 – Signatures

### Signature applies to Sections 1 through 14. Review before signing.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City State Month Year

Signature of Proposed Insured or personal representative

Description of personal representative's authority to act

Signature of Owner (If other than Proposed Insured)

## SECTION 16 – Agent's Certification and Signature

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

I certify that I have provided the Owner a copy of the Terminal Illness Accelerated Benefit Disclosure Statement and a numerical illustration.

X \_\_\_\_\_ X \_\_\_\_\_  
Printed Agent Name Agent's Signature

Agent Code \_\_\_\_\_ Agent's E-Mail \_\_\_\_\_

Agent: Phone # \_\_\_\_\_ Fax# \_\_\_\_\_ License Identification Number (\_\_\_\_\_) \_\_\_\_\_  
State

PLEASE DETACH AND GIVE TO APPLICANT

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

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

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

**I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.**

**RECEIPT**

Received from \_\_\_\_\_ The sum of \$ \_\_\_\_\_

Being the 1st premium of \_\_\_\_\_ mode

Type of proposed insurance \_\_\_\_\_ Amount of proposed insurance \$ \_\_\_\_\_

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

Dated at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_  
Month Day Year

Agent Signature \_\_\_\_\_

**FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE**

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

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

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

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

**IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION**

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

**Terminal Illness Accelerated Benefit Disclosure Statement**

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

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

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

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

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

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

Death Benefit	\$100,000.00
Less 7%	<u>6,542.06</u>
Accelerated Benefit	<b>\$ 93,457.94</b>

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

# ELECTRONIC FUND TRANSFER (EFT)

## AUTHORIZATION FORM

225 South East Street • P.O. Box 7192 • Indianapolis, IN 46207-7192

Phone: 1-800-428-3001

Fax: New Policy Application: 317-692-7711

Fax: Existing In Force Policy: 317-692-8402



### Section 1 – Financial Institution Information - Always Complete This Section

Financial Institution Name		
Financial Institution Address		
Account Number	Routing Number	Type of Account (check one) <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Account Holder Printed Name		Relationship if other than Owner

### Section 2 – Complete This Section For A New Policy Application

Name of Proposed Insured
The initial modal premium must be quoted in the payment information section of the application. We do not accept debit or credit cards at the time of application. <b>I understand that the policy will not be effective until the later of: the date it is issued by the Company as applied for and the premium paid; or the date of the Owner's written acceptance of the policy if issued other than applied for and the premium paid.</b>
1. Draft my account for the <b>first</b> premium (check one):  <input type="checkbox"/> Immediately upon receipt of the application in the Home Office. <input type="checkbox"/> On the date of issue (policy date). <input type="checkbox"/> On _____ (month & day). Choose any day between the 1 <sup>st</sup> and the 28 <sup>th</sup> . <input type="checkbox"/> On the [ <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> ] (check one) Wednesday of _____ (month). <input type="checkbox"/> Do NOT draft my account for the first premium. The first premium is attached, is being mailed, or will be collected on delivery. The Company name should appear as the Payee. Do not leave the Payee field blank, do not make payable to the agent, and do not postdate. Do not pay with cash.
2. Unless indicated below all <b>subsequent</b> premiums will be drafted on the same day each month as the <b>first</b> premium.  Draft subsequent premiums on the _____ (1 <sup>st</sup> – 28 <sup>th</sup> ) day of each month.

### Section 3 – Complete This Section For An Existing In Force Policy

Name of Insured	Policy Number
Requested draft day _____ (1 <sup>st</sup> – 28 <sup>th</sup> ) <b>OR</b> the [ <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> ] (check one) Wednesday of each month. If day is not specified, the draft day will be based upon the date of issue (policy date).	

### Section 4 – Authorization – Always Complete This Section

I request and authorize my financial institution to honor deductions from my account that are initiated by United Home Life Insurance Company or United Farm Family Life Insurance Company (the "Company") for the current policy premium, including policy renewals and/or changes. By signing below, I authorize the Company to receive information from the financial institution named so my account number and routing number may be verified.

I understand and agree that the Company is not responsible for any charges from my financial institution and that a dishonored deduction will not be resubmitted and may cause the policy to lapse for non-payment of premium. I may terminate this EFT Authorization by giving 15 days prior written notice to the Company. The Company may terminate this EFT Authorization agreement upon any deduction returned as dishonored, or upon 15 days prior written notice.

Account Holder Signature _____	Date _____
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### HOME OFFICE USE ONLY

Call Representative/ACID	Date	Time	Call ID#
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200-188 2-17





**UNITED HOME LIFE INSURANCE COMPANY**  
**P.O. Box 7192**  
**Indianapolis, IN 46207-7192**  
**Phone: (317) 692-7979 Fax: (317) 692-7711**

**IMPORTANT NOTICE:  
 REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

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 interests. 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.

**Do you have any existing insurance policies or annuities? \_\_\_\_ YES \_\_\_\_ NO**

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

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (including 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:

	<b>Insurer Name</b>	<b>Contract Or Policy #</b>	<b>Insured Or Annuitant</b>	<b>Replaced (R) Or Financing (F)</b>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

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 \_\_\_\_\_

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

\_\_\_\_\_  
 Applicant's Signature and Printed Name Date

\_\_\_\_\_  
 Producer's Signature and 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.)

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 HOME LIFE INSURANCE COMPANY**  
**P.O. Box 7192**  
**Indianapolis, IN 46207-7192**  
**Phone: (317) 692-7979 Fax: (317) 692-7711**

**IMPORTANT NOTICE:  
 REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

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 interests. 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.

**Do you have any existing insurance policies or annuities? \_\_\_\_ YES \_\_\_\_ NO**

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

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (including 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:

	<b>Insurer Name</b>	<b>Contract Or Policy #</b>	<b>Insured Or Annuitant</b>	<b>Replaced (R) Or Financing (F)</b>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

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 \_\_\_\_\_

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

\_\_\_\_\_  
 Applicant's Signature and Printed Name Date

\_\_\_\_\_  
 Producer's Signature and 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.)

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.  
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**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

Will you pay surrender charges on your old contract?  
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