United Farm Family Life Insurance Company

TERM LIFE

Regular Mail:
United Farm Family 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 Farm Family 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. _____

_____

Did you provide the Owner and Proposed Insured a completed Disclosure Statement (form 18-658 1-12 (PA)) and submit the signed Certificate of Delivery? [ ] Yes [ ] No

If No, the application cannot be processed.

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 UFFL 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: UFFL 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. **UFFL TERM PRODUCTS USE THE "AGE LAST BIRTHDAY" METHOD FOR DETERMINING THE AGE OF THE PROPOSED INSURED FOR INSURANCE PURPOSES.**
2. **Be sure to leave a signed copy of the Terminal Condition Limited Life Expectancy Accelerated Benefit Disclosure Statement, form 18-328 1-12 (PA), with the Owner and include a signed copy with the application.**
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 Farm Family 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	❑ Male ❑ Female

Marital Status	Height	Weight

Social Security Number	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:*

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 ❑ Simple Term 20 ❑ Simple Term 30 ❑ Simple Term 20 DLX ❑ 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.	Face Amount: $_____
❑ Accidental Death Benefit $ _____	
❑ Waiver of Premium (not available with Simple Term 20 DLX)	

SECTION 5 – Payment Information

Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly EFT* Modal Premium Amount $_____

$_____ paid with application.

***If selected, complete EFT authorization form.**

SECTION 6 – Other Insurance

Will this insurance replace or change any existing life insurance policies or annuities? ❑ 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 medically advised 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.)	❑ Yes ❑ 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?	❑ Yes ❑ No
C. **In the past 5 years** 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?	❑ Yes ❑ No
D. **In the past twelve (12) months:**	
1. Other than for temporary or minor conditions, have you been hospitalized two or more times?	❑ Yes ❑ No
2. Have you used any illegal drugs?	❑ Yes ❑ No
E. **In the past 5 years:**	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer's Disease or Dementia?	❑ Yes ❑ No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	❑ Yes ❑ No
c. Other than preventive, maintenance, or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension) or Stroke?	❑ Yes ❑ No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	❑ Yes ❑ No
e. Sickle Cell Anemia?	❑ Yes ❑ No
f. Kidney Disease (including dialysis, nephropathy) or Liver Disease (including hepatitis B & C)?	❑ Yes ❑ No
g. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	❑ Yes ❑ No
h. ALS (Lou Gehrig's Disease) or Neurological disorders (including neuropathy, excluding controlled seizure disorder with no seizures in the past 2 years)?	❑ Yes ❑ 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?	❑ Yes ❑ No
3. Have you been medically treated for or been medically advised to have treatment for alcohol or drug dependency or consumed more than 10 alcoholic drinks per day?	❑ Yes ❑ No
F. **In the past 10 years** have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	❑ Yes ❑ 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. **In the past 2 years** have you been declined or postponed for Life Insurance?	❑ Yes ❑ No
B. **In the past 5 years:**	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	❑ Yes ❑ No

b. Diabetes requiring insulin treatment?	❑ Yes ❑ No
c. SLE (Systemic Lupus Erythematosus)?	❑ Yes ❑ No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	❑ Yes ❑ No
C. Are you currently disabled, or been 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?	❑ Yes ❑ No
D. Do you now participate in, or do you have plans to participate in any hazardous sport or aviation?	❑ Yes ❑ 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. All statements on this application are true and complete to the best of the knowledge and belief of the individuals who made them. 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 Farm Family Life Insurance Company unless such information is in writing and made a part of this application. I UNDERSTAND COVERAGE WILL NOT BE EFFECTIVE UNTIL THE LATER OF: THE DATE THE FIRST PREMIUM IS PAID AND THE POLICY IS DELIVERED TO THE OWNER; OR THE DATE OF THE OWNER'S WRITTEN ACCEPTANCE OF THE POLICY IF DELIVERED OTHER THAN APPLIED FOR AND THE FIRST 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 and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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 Farm Family Life Insurance Company ("UFFL") or its reinsurer(s) any such information. UFFL may also disclose such information to reinsurers, MIB, persons or entities performing business, professional, or insurance functions for UFFL or as may otherwise be legally allowed. I further authorize UFFL 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 or AIDS.

I understand that UFFL 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 Farm Family Life Insurance Company and its agents, employees, and representatives. United Farm Family Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Farm Family 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 Farm Family 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 Farm Family 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 Farm Family 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 Farm Family 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 Farm Family 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 – Signatures

Signature applies to Sections 1 through 13. Review before signing.

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

_____
Signature of Proposed Insured

_____
Signature of Owner (If other than Proposed Insured)

SECTION 15 – Agent's Certification and Signature

To the best of my knowledge and belief the insurance applied for herein is ☐ is not ☐ intended to replace or change any existing life insurance or annuity coverage.

X _____ (Printed Agent Name) **X** _____ (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 FARM FAMILY LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192**

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

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

I UNDERSTAND COVERAGE WILL NOT BE EFFECTIVE UNTIL THE LATER OF: THE DATE THE FIRST PREMIUM IS PAID AND THE POLICY IS DELIVERED TO THE OWNER; OR THE DATE OF THE OWNER'S WRITTEN ACCEPTANCE OF THE POLICY IF DELIVERED OTHER THAN APPLIED FOR AND THE FIRST 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 Farm Family 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 Farm Family Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

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

UNITED FARM FAMILY LIFE INSURANCE COMPANY

TERMINAL CONDITION LIMITED LIFE EXPECTANCY ACCELERATED BENEFIT

DISCLOSURE STATEMENT

THERE WILL BE NO DEATH BENEFIT PAYABLE UNDER THE POLICY NOR WILL ANY ADDITIONAL PREMIUM PAYMENTS BE DUE AFTER AN ACCELERATED BENEFIT IS PAID.

THIS BENEFIT WILL END UPON TERMINATION OF THE POLICY TO WHICH THE RIDER IS ATTACHED.

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 Limited Life Expectancy Terminal Condition Benefit Rider.

Conditions

Payment of the accelerated benefit is subject to the following conditions:

1. The policy must be in force; and
2. The payment of the accelerated benefit must be approved in writing by any irrevocable beneficiary or assignee.

Effect on the Policy

When the accelerated benefit is paid, the policy terminates.

I ACKNOWLEDGE RECEIPT OF THIS DISCLOSURE

_____ _____

Signature of Agent Date Signature of Owner Date

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

UNITED FARM FAMILY LIFE INSURANCE COMPANY

TERMINAL CONDITION LIMITED LIFE EXPECTANCY ACCELERATED BENEFIT

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Conditions

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1. The policy must be in force; and
2. The payment of the accelerated benefit must be approved in writing by any irrevocable beneficiary or assignee.

Effect on the Policy

When the accelerated benefit is paid, the policy terminates.

I ACKNOWLEDGE RECEIPT OF THIS DISCLOSURE

_____ _____

Signature of Agent Date Signature of Owner Date

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

UNITED FARM FAMILY LIFE INSURANCE COMPANY

Commonwealth of Pennsylvania
DISCLOSURE STATEMENT

THIS DISCLOSURE STATEMENT WITH ALL APPLICABLE BLANKS FILLED IN IS FOR YOUR PROTECTION. IT GIVES YOU BASIC INFORMATION ABOUT THE COST AND COVERAGE OF THE INSURANCE BEING SOLICITED. READ IT CAREFULLY BEFORE SIGNING ANY AGREEMENT TO BUY LIFE INSURANCE.

THIS DISCLOSURE STATEMENT SHALL NOT BE CONSIDERED AS AN OFFER TO CONTRACT OR AS ALTERING OR MODIFYING ANY POLICY OR RIDER THAT MAY BE ISSUED.

Name of Proposed Insured: _____ Age: _____ Sex: _____

Name of Agent Preparing Disclosure: _____

Agent Home or Agency Address: _____

Telephone Number of Agent: _____

Name of Insurer: United Farm Family Life Insurance Company

Home Office Address of Insurer: 225 S. East Street, Indianapolis, IN 46202

Direct all correspondence to: United Farm Family Life Insurance Company's Home Office

	Descriptive Title of Coverage	Face Amount of Coverage (1) If not applicable, Description of Coverage	Annual Premium If not known, Premium for Mode Quoted (2)
Policy			
Rider(s)			
Supplemental Benefit(s) (Built into Policy)			The cost is included in the premium for the policy.

(1) The face amount of coverage of the policy changes as follows: _____

_____

(2) The premium for the policy and riders changes; the ultimate annual premium will be $_____ at _____ policy year.

Guaranteed Cash Value: If you continuously pay your premiums on this policy as they come due, you will have the following guaranteed cash value for each $1,000 of Face Amount. You may borrow against this cash value at an annual _____% loan interest charge.

Number of Years Policy Has Been In Force	5	10	20	Age 65
Total Accumulated Cash Value per $1,000				

A Surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one means of comparing the relative costs of two or more similar policies. (Not applicable for Term Life Insurance.)

The prospective insured has _____ has not _____ requested an earlier delivery of the Index.

Upon request, either the company or agent will furnish you with additional information about the insurance described.

United Farm Family Life Insurance Company

Commonwealth of Pennsylvania
Certificate of Delivery

Re: _____
Proposed Insured

I hereby certify that a written disclosure statement of the policy applied for was given to the applicant no later than the time that the application was signed by the applicant.

_____ _____
Date Agent

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) ☐ Checking ☐ 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. **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.**

1. Draft my account for the **first** premium (check one):

   ☐ Immediately upon receipt of the application in the Home Office.
   ☐ On the date of issue (policy date).
   ☐ On _____ (month & day). Choose any day between the 1st and the 28th.
   ☐ On the [☐ 2nd ☐ 3rd ☐ 4th] (check one) Wednesday of _____(month).
   ☐ 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 **subsequent** premiums will be drafted on the same day each month as the **first** premium.

   Draft subsequent premiums on the _____ (1st – 28th) day of each month.

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

Name of Insured	Policy Number

Requested draft day _____ (1st – 28th) **OR** the [☐ 2nd ☐ 3rd ☐ 4th] (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 _____

HOME OFFICE USE ONLY

Call Representative/ACID _____ Date _____ Time _____ Call ID# _____

United Farm Family Life Insurance Company
P.O. Box 7192
Indianapolis, Indiana 46207-7192
1-800-428-3001

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

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

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

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

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

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

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

LIST ALL EXISTING LIFE INSURANCE TO BE REPLACED

Company Name	Policy Number	Name of Insured

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

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

Applicant's Signature _____ Date _____

Agent's Signature _____ Date _____

United Farm Family Life Insurance Company
P.O. Box 7192
Indianapolis, Indiana 46207-7192
1-800-428-3001

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

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

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

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

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

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

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

LIST ALL EXISTING LIFE INSURANCE TO BE REPLACED

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