

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



OKLAHOMA – APPLICATION FOR LIFE INSURANCE

LIVING PROMISE PRODUCT – 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
FAX: 1-402-997-1800

PLEASE CHOOSE THE PRECISE PLAN, RIDER, AND AMOUNT OF INSURANCE APPLIED FOR

LEVEL BENEFIT PRODUCT:

- Accelerated Death Benefit Rider
- Accidental Death Benefit Rider (OPTIONAL)

GRADED BENEFIT PRODUCT (IF AVAILABLE):

- No Riders Available

APPLICATION SUBMISSION GUIDELINES

- Attach a cover letter or additional information as needed.
- Always submit the Producer Report page.
- Leave all applicable forms and Life Buyer's Guide with the Proposed Insured.
- All changes should be initialed and dated 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.

IMPORTANT FORMS

- Replacement Notice – if applicable, the client must sign and retain a copy for their records
- Payment Authorization – Complete this form if applicable
- Conditional Receipt – Complete **ONLY** if you accepted a check or electronic transaction authorization at time of application for the initial premium. **DO NOT** complete the Conditional Receipt if initial payment won't be collected until issue.
- Accelerated Benefit Rider Disclosure – The client must sign the Accelerated Benefit Rider Disclosure Form
- Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor - Complete this form if applicable. The client must sign and retain a copy for their records.

Supplemental Forms and Buyer's Guide:

- **Buyer's Guide:** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale.



LAP1162_OK_0613

08/18/2017

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL OF OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



Application for Individual Life Insurance

PROPOSED INSURED										
Name (First, Middle Initial, Last)					Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Height	Weight	Social Security No.	
Home Address (Street, City, State, Zip)						State of Birth		Date of Birth	Age	
Phone No.		E-mail			Driver's License No.			Driver's License State		
Are you a legal resident of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", you are not eligible for coverage.)						In the past 12 months, has the Proposed Insured used any form of tobacco or nicotine replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No				
OWNER (Complete only if Owner/Applicant is different from Proposed Insured)										
Name of Policyowner (First, Middle Initial, Last)						Relationship to Proposed Insured				
Policyowner Address (Street, City, State, Zip)						Phone No.		Social Security No.		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth		Age	E-mail			Citizenship Country			
UNDERWRITING										
Part One IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN PART ONE, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.										
1. Is the Proposed Insured currently:										
(a) bedridden or confined to any hospital, nursing home, long-term care facility or skilled nursing facility; or receiving or been advised to receive care in a nursing home, hospice care, or home health care?										<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) requiring assistance with activities of daily living such as taking medications, bathing, dressing, eating, toileting, getting in and out of a chair or bed, or control of bowel or bladder problems?										<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) requiring any of the following (other than for fractures, bone or joint surgery, including replacement): wheelchair, electric scooter, or oxygen equipment to assist breathing (excluding use for sleep apnea)?										<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the Proposed Insured ever been :										
(a) diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider?										<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Quadriplegia, Paraplegia, Down's Syndrome, mental incapacity, congestive heart failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type?										<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed with End Stage Renal Disease or requiring dialysis?										<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) advised to receive or have received an organ or bone marrow transplant?										<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) diagnosed by a physician or health care provider as having a terminal medical condition that is expected to result in death within the next 12 months?										<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 12 months, has the Proposed Insured been:										
(a) advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known?										<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind? . .										<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for any form of cancer (except basal or squamous cell skin cancer)?										<input type="checkbox"/> Yes <input type="checkbox"/> No

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Part Two IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTION IN PART TWO, THAT PERSON IS ELIGIBLE ONLY FOR THE GRADED BENEFIT PRODUCT.

<p>5. Has the Proposed Insured ever (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:</p> <p>(a) Diabetes before age 50 or diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)?</p> <p>(b) Hepatitis C?</p> <p>(c) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>6. In the past 4 years, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:</p> <p>(a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)? ...</p> <p>(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?</p> <p>(c) Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>7. In the past 2 years, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:</p> <p>(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement?</p> <p>(b) Stroke or Transient Ischemic Attack (TIA)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. In the past 2 years, has the Proposed Insured:</p> <p>(a) been convicted of or currently awaiting trial for a felony?</p> <p>(b) been treated for or advised to have treatment for alcohol or drug abuse or convicted more than once of reckless driving or driving under the influence of drugs or alcohol?</p> <p>(c) used unlawful drugs in any form or abused or misused prescription drugs?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>9. In the past 2 years, has the Proposed Insured been hospitalized by a physician or health care provider for any mental or nervous disorder?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. In the past 12 months, has the Proposed Insured consulted a physician for chronic cough, <u>unexplained</u> weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

NOTE: If the Proposed Insured answers all above questions "No", that person is eligible for the Level Benefit Product.

OPTIONAL COMMENTS (Not Required) - Provide any additional information available.

Question Number	Details to Underwriting Questions (Diagnosis, Dates, Durations, Medications, Dosages)

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PLAN INFORMATION

Plan: <input type="checkbox"/> Level Benefit Product <input type="checkbox"/> Graded Benefit Product Amount Applied For \$ _____	Rider: (Only if selecting Level Benefit Product) <input type="checkbox"/> Accidental Death Rider
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Payment Mode:
 Annual Semiannual Quarterly Monthly (Automated Bank Account Withdrawal)
 Modal Premium \$ _____ Collected Premium \$ _____

BENEFICIARY (If more space is needed, list on a separate sheet)

Primary Beneficiary	Relationship to Insured	Date of Birth
Contingent Beneficiary	Relationship to Insured	Date of Birth

OTHER COVERAGE INFORMATION

1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company? Yes No
2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with the company or any other company? Yes No
 If "Yes" to questions #1 or #2, please give details below. If more space is needed, list on a separate sheet.

Company	Proposed Insured	Face Amount	To be Replaced or Converted?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZATION and AGREEMENT

Authorization: I authorize any medical provider, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical care facility, MIB, Inc. (MIB), state department of motor vehicles and other entities processing motor vehicle records, insurance companies or consumer reporting agencies to release information about me or my health, such as, medical history, including the presence of HIV infection, AIDS or ARC, mental or physical condition, prescription drug records, drug or alcohol use, driving record or insurance claims information, to United of Omaha Life Insurance Company ("United of Omaha"). **Such release may include information, which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, Human Immunodeficiency Virus (HIV) Infection, and Acquired Immune Deficiency Syndrome (AIDS).** The information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise. I also authorize United of Omaha to disclose information to MIB. I understand that my information received by MIB 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. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations. This authorization is valid for 24 months from the date signed. I may refuse to sign this authorization but if I refuse, the insurance I am applying for will not be issued. I may revoke this authorization at any time by written notice to the address below. This revocation is limited to the extent that United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha to contest the issuance of the policy or a claim under the policy. I will receive a copy of this authorization.

Agreement: I represent that any and all answers to the questions in this application are true and complete to the best of my knowledge and belief and will be used by United of Omaha to determine my insurability. I also understand that coverage will not be in force until this application is completed in full and approved by United of Omaha, all outstanding application requirements have been received, my initial premium has been received and a policy has been issued, all during my lifetime. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issue. Coverage under the policy, if issued, will be effective on the policy issue date shown in the policy. The initial premium will provide coverage from the policy issue date until the date the next premium is due.

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- CONTINUED ON NEXT PAGE -



Fraud 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.

If applying for the Graded Benefit Product: I understand that a reduced death benefit amount is payable during the first two policy years if death results from sickness or other natural causes. The full face amount is payable during the first two policy years if death results from an accident.

Signed at: _____

City State

Date: _____

Signature of Proposed Insured

Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)

Date: _____

Producer Statement:

By signing below, I/we, the Producer(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

1. 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
2. Do you, the Producer(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy or annuity contract in force with the company or any other company? Yes No
3. Has the Proposed Insured informed you, the Producer(s), that he/she has any pending or existing life insurance or annuity contracts with the company or any other company?..... Yes No

(If the above questions are answered "Yes," fulfill all state and company requirements.)

4. Are you related to the Proposed Insured or Owner? Yes No

If "Yes," state relationship _____

5. How long have you known the Proposed Insured? _____

6. How long have you known the Proposed Owner? _____

7. Previous residence of Proposed Insured for the past five years.

Street Address	City	State	Zip Code

8. I/We conducted said interview in person Yes No

If "No," please explain _____

Signature of Producer #1 Producer E-mail Production Number Date

Signature of Producer #2 Producer E-mail Production Number Date

Print Producer #1 Name Print Producer #2 Name Agency Name

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Producer Report

1 Was a Personal Health Interview (PHI) conducted by Apptical Corporation as a part of the application process?..... Yes No

If Yes, please provide the PHI number_____

2 List any additional information or comments below:

L8532_0615



UNITED OF OMAHA LIFE INSURANCE COMPANY

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



PAYMENT AUTHORIZATION FORM

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

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

PAYMENT INFORMATION FOR THE FIRST PAYMENT- CAN BE DIFFERENT THAN THE ONGOING PAYMENTS

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

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

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

PAYMENT INFORMATION FOR ONGOING PAYMENTS- AUTOMATIC BANK ACCOUNT DEDUCTION

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

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

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

PAYOR INFORMATION

Name of payor as shown on bank account: _____

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

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

PAYOR ACCOUNT INFORMATION

- Account Type (check one): Checking Savings
- Name of Financial Institution: _____
- 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: _____	
⑆123456789⑆ 12345678 ⑆ 1234 ⑆		
Bank Routing Number	Bank Account Number	Check Number (if shown at bottom, may be shown before or after the account #)

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

CONDITIONAL RECEIPT (“RECEIPT”)

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


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

DATE OF RECEIPT: _____

BENEFIT	For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) \$40,000 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 Conditional Receipt benefit under this Receipt exceed \$40,000.
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CONDITIONS	<p>Conditions under which a benefit may be payable under this Receipt prior to policy delivery:</p> <ol style="list-style-type: none"> 1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and 2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and 3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and 4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United. <p>If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.</p>
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END DATE	<p>This Receipt and any coverage provided hereunder will END on the earliest of the following dates:</p> <ol style="list-style-type: none"> 1 60 days from the date of this Receipt; 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 the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or 4 The date the Applicant/Owner withdraws the application for insurance.
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SIGNATURES	<p>This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt 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.</p> <p>I/We have read and received a copy of this Receipt 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 Receipt.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Signature of Proposed Insured _____</td> <td style="width: 50%; border: none;">Date _____</td> </tr> <tr> <td style="border: none;">Signature of Other Proposed Insured _____</td> <td style="border: none;">Date _____</td> </tr> <tr> <td style="border: none;">Signature of Applicant/Owner (if other than Proposed Insured) _____</td> <td style="border: none;">Date _____</td> </tr> </table> <p>Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> Amount remitted/authorized \$ _____</p> <p>I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Signature of Producer _____</td> <td style="width: 50%; border: none;">Date _____</td> </tr> <tr> <td style="border: none;">Signature of Producer _____</td> <td style="border: none;">Date _____</td> </tr> </table> <div style="text-align: center; margin-top: 10px;">  </div>	Signature of Proposed Insured _____	Date _____	Signature of Other Proposed Insured _____	Date _____	Signature of Applicant/Owner (if other than Proposed Insured) _____	Date _____	Signature of Producer _____	Date _____	Signature of Producer _____	Date _____
Signature of Proposed Insured _____	Date _____										
Signature of Other Proposed Insured _____	Date _____										
Signature of Applicant/Owner (if other than Proposed Insured) _____	Date _____										
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 the rider may be taxable. Receipt of the accelerated death 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 the benefit.

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness or Nursing Home Confinement 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 or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

While the rider is in force and the insured has a terminal illness or is under nursing home confinement, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. Nursing home confinement means that the insured has been confined to a nursing home for at least 90 consecutive days and is expected to remain confined for the remainder of his or her life. A physician must certify that the insured has a terminal illness or is under nursing home confinement.

The amount available for the accelerated death benefit is your policy's death benefit. You may receive the accelerated death benefit only once.

For a terminal illness, we will reduce the accelerated death benefit by 6%.

For nursing home confinement, we will reduce the accelerated death benefit by the nursing home confinement factor. The nursing home confinement factor varies by policy year as shown in the rider. We will also reduce the accelerated death benefit by a \$100 charge and by the amount of any loans and unpaid premiums.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The rider will terminate when the accelerated death benefit is paid.

NOTE: If the policy is issued as a graded death benefit, the accelerated death benefit is not available.

Acknowledgment

I acknowledge receipt of this disclosure form.

Applicant/Owner Signature

Date

I have provided this disclosure form to the applicant/owner.

Producer Signature

Date



AUTHORIZATION FOR RELEASE OF INFORMATION TO MY INSURANCE AGENT, AGENCY AND/OR AUTHORIZED THIRD PARTY VENDOR

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.



I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

 X _____ Signature of Applicant A	_____ Date	 X _____ Signature of Applicant B	_____ Date
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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).



CONDITIONAL RECEIPT (“RECEIPT”)

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

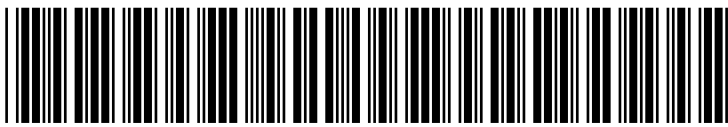
IF ANY PROPOSED INSURED DIES WHILE COVERAGE UNDER THIS RECEIPT IS IN EFFECT, WE WILL PAY TO THE BENEFICIARY(IES) NAMED IN THE APPLICATION THE AMOUNT DESCRIBED IN THE SECTION BELOW ENTITLED “BENEFIT”.

DATE OF RECEIPT: _____

BENEFIT	For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) \$40,000 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 Conditional Receipt benefit under this Receipt exceed \$40,000.
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CONDITIONS	<p>Conditions under which a benefit may be payable under this Receipt prior to policy delivery:</p> <ol style="list-style-type: none"> 1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and 2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and 3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and 4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United. <p>If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.</p>
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END DATE	<p>This Receipt and any coverage provided hereunder will END on the earliest of the following dates:</p> <ol style="list-style-type: none"> 1 60 days from the date of this Receipt; 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 the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or 4 The date the Applicant/Owner withdraws the application for insurance.
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SIGNATURES	<p>This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt 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.</p> <p>I/We have read and received a copy of this Receipt 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 Receipt.</p> <p>Signature of Proposed Insured _____ Date _____</p> <p>Signature of Other Proposed Insured _____ Date _____</p> <p>Signature of Applicant/Owner (if other than Proposed Insured) _____ Date _____</p> <p>Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> Amount remitted/authorized \$ _____</p> <p>I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.</p> <p>Signature of Producer _____ Date _____</p> <p>Signature of Producer _____ Date _____</p> <div style="text-align: center;">  </div>
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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, Braintree, 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.



Applicant's/Owner's Copy

L7941

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness or Nursing Home Confinement 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 or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

While the rider is in force and the insured has a terminal illness or is under nursing home confinement, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. Nursing home confinement means that the insured has been confined to a nursing home for at least 90 consecutive days and is expected to remain confined for the remainder of his or her life. A physician must certify that the insured has a terminal illness or is under nursing home confinement.

The amount available for the accelerated death benefit is your policy's death benefit. You may receive the accelerated death benefit only once.

For a terminal illness, we will reduce the accelerated death benefit by 6%.

For nursing home confinement, we will reduce the accelerated death benefit by the nursing home confinement factor. The nursing home confinement factor varies by policy year as shown in the rider. We will also reduce the accelerated death benefit by a \$100 charge and by the amount of any loans and unpaid premiums.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The rider will terminate when the accelerated death benefit is paid.

NOTE: If the policy is issued as a graded death benefit, the accelerated death benefit is not available.

Acknowledgment

I acknowledge receipt of this disclosure form.

Applicant/Owner Signature

Date

I have provided this disclosure form to the applicant/owner.

Producer Signature

Date



AUTHORIZATION FOR RELEASE OF INFORMATION TO MY INSURANCE AGENT, AGENCY AND/OR AUTHORIZED THIRD PARTY VENDOR

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.



I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

 X _____ Signature of Applicant A	_____ Date	 X _____ Signature of Applicant B	_____ Date
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UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

STATEMENT BY APPLICANT REGARDING NOTIFICATION OF REPLACEMENT TO THE REPLACED INSURER

I have read the "Notice to Applicants Regarding Replacement of Life Insurance or an Annuity" which was furnished to me by the agent taking the application for this policy.

(Applicant: Please sign one of the following statements.)

1. Please notify my present insurer(s) regarding this transaction.

Date

Signature of Applicant/Owner

2. Please do not notify my present insurer(s) regarding this transaction.

Date

Signature of Applicant/Owner

The signature of the applicant shall be that of the Insured unless someone other than the Insured is the owner of the policy. If someone other than the Insured is the owner of the policy, the owner must sign. If the Insured is under 18 years of age, the parent is deemed to be the owner of the policy.

Certification by the agent:

I hereby certify that nothing was said or done during the sales presentation to influence the decision of the applicant regarding this statement.

Date

Signature of Agent

Insurance Agency or Agent
License Number



UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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Certification by the agent:

I hereby certify that nothing was said or done during the sales presentation to influence the decision of the applicant regarding this statement.

Date

Signature of Agent

Insurance Agency or Agent
License Number



Definitions

Premiums: Premiums are the payments you make on the life insurance or annuity contract. They are unlike deposits in a savings or investment program because if you drop the policy, you might get back less than you paid in.

Cash Surrender Value: This is the amount of money you can get if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and the loan value. Not all policies have cash surrender values.

Lapse: A life insurance policy may lapse when you do not pay the premiums within the grace period. If your policy had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid-up insurance as the cash surrender value will buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the premiums.

Surrender: You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. If a policy has a cash surrender value, you can receive such value in cash if you return the policy to the Company with a written request.

Place on Extended Term: This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same as before but you will only be covered for a specified period of time.

Borrow Policy Loan Values: If your life insurance policy has a cash surrender value, you can usually borrow all or part of said amount from the insurer. Interest will be charged according to the terms of the policy, and if the loan and any unpaid interest due will be subtracted from the death benefits.

Evidence of Insurability: This means proof that you are an acceptable risk. You have to meet the standards of the insurer regarding age, health, occupation and such other standards as the insurer feels necessary to be eligible for coverage.

Incontestable Clause: This says that after one (1) or two (2) years, according to the provisions of the contract, the insurer shall not resist a claim because you made a false or incomplete statement when you applied for the policy. During the first (2) years if there are false or incomplete answers on the application and the insurer discovers them, the insurer can deny a claim as if the policy has never existed.

Suicide Clause: This says that if you commit suicide after being insured for less than two (2) years, your beneficiaries will receive only a refund of the premiums that were paid.



UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Notice To Applicants Regarding Replacement of Life Insurance or an Annuity

This notice is for your benefit and is required by law.

1. If you are urged to purchase life insurance and to surrender, lapse or in any other way change the status of existing life insurance, the agent is required to give you this notice.
2. It may not be advantageous to drop or change existing life insurance in favor of new life insurance, whether issued by the same or a different insurance company. Some of the disadvantages are:
 - (a) The amount of the annual premium under an existing policy may be lower than that under a new policy having the same or similar benefits.
 - (b) Generally, the initial costs of life insurance policies are charged against the cash value increases in the earlier policy years, the replacement of an old policy could result in the policyholder sustaining the burden of these costs twice.
 - (c) **THE INCONTESTABLE AND SUICIDE CLAUSES BEGIN ANEW IN A NEW POLICY. THIS COULD RESULT IN A CLAIM UNDER A NEW POLICY BEING DENIED BY THE COMPANY WHICH WOULD HAVE BEEN PAID UNDER THE OLD POLICY.**
 - (d) Existing policies may have more favorable provisions than new policies in such areas as settlement options and disability benefits.
 - (e) An existing policy may have a reserve value in addition to any cash value which may be of some benefit to the Insured.
 - (f) The insurance company carrying your current insurance policy can often make a desired change on terms which would be more favorable than if existing insurance is replaced with new insurance.
3. It may not be advantageous to change an existing policy to reduced paid-up or extended term insurance or to borrow against its loan value beyond your expected ability or intention to repay in order to obtain funds for premiums on a new policy.
4. There may be a situation in which a replacement policy is advantageous. You may want to receive the comments of the present insurance company before deciding this important financial matter.

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

I hereby acknowledge that I received the above "Notice to Applicants Regarding Replacement of Life Insurance or an Annuity" before I signed the application for the proposed new insurance.

Date

Signature of Applicant/Owner



UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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Date

Signature of Applicant/Owner





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.

