



FINAL EXPENSE

WHOLE 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? <input type="checkbox"/> E-Mail <input type="checkbox"/> Fax	
Proposed Insured's Name: _____	
Do you personally know the Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you written insurance on the Proposed Insured in the past three (3) years? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No, how was the application taken? Solicited by: <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Internet <input type="checkbox"/> Fax <input type="checkbox"/> Other _____ (Explain)	
Did you identify any unusual behavior or suspicious activity by the Owner or Proposed Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please explain. _____ _____	
If the application is being submitted for the Guaranteed Issue Whole Life, by affixing my signature to the Agent's Certification and Signature section of the application I hereby affirm that I was personally present with the Proposed Insured when the application was completed, and: (1) the Proposed Insured is not confined to a hospital, hospice, nursing home, convalescent home, or does not require home health nursing care; (2) to my knowledge the Proposed Insured is not HIV+ or does not have AIDS or any terminal illness (any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months); and (3) I have no knowledge of intravenous drug abuse (IVDA) of the Proposed Insured.	
Special Instructions you want us to know: _____ _____	

MAIL POLICY TO: Owner Agent

Personal History Interviews (PHIs):

Do **NOT** complete a PHI if the application being submitted is for the GIWL (Graded Death Benefit Endowment).

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 EIWL (graded benefit), Deluxe or Premier 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 EIWL, Deluxe and Premier 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 WHOLE LIFE PRODUCTS USE THE "AGE LAST BIRTHDAY" METHOD FOR DETERMINING THE AGE OF THE PROPOSED INSURED FOR INSURANCE PURPOSES.**
2. **The minimum face amount for the GIWL or EIWL is \$7,000.**
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. Signature of spouse is required in community property states when a person other than the Owner's spouse is named as primary beneficiary with a Share % greater than 50.
9. 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.
10. 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.
11. **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.**

Application for Life Insurance

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 for Proposed Insureds under age 65)				

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

Owner Name		Marital Status		
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"/> Express Issue Premier <input type="checkbox"/> Express Issue Deluxe <input type="checkbox"/> Express Issue Whole Life <input type="checkbox"/> Guaranteed Issue Whole Life (Graded Death Benefit Endowment) <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 graded death benefit in the first 2 or 3 years, 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: \$ _____
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If the Face Amount shown above is \$10,000 or greater and the product issued is the Express Issue Whole Life, the following riders will be attached to the policy: Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

Accidental Death Benefit Rider (not available with Guaranteed Issue WL or Express Issue WL) \$ _____

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 other 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

If the plan selected in Section 4 is the Guaranteed Issue Whole Life, the Proposed Insured should not answer the health questions below.

PART A - EXPRESS ISSUE WHOLE LIFE – COMPLETE PART A ONLY

If any question in Part A is answered "Yes", the Proposed Insured is not eligible for Express Issue Whole Life.

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 been diagnosed or treated by a member of the medical profession for immune deficiency disorder, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or test results indicating exposure to the AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. In the past twelve (12) months:	
1. Have you been hospitalized two or more times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Other than preventive, maintenance, or risk lowering medications prescribed, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), heart attack, stroke, or had heart surgery (including angioplasty)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you used any illegal drugs, been treated for or advised to have treatment for drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART B - EXPRESS ISSUE DELUXE – COMPLETE PARTS A & B ONLY

If any question in Part B is answered "Yes", the Proposed Insured is not eligible for Express Issue Deluxe. Submit the case as Express Issue Whole Life.

A. In the past 2 years:	
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. 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?	<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 excessively used, been treated for, or been advised to have treatment for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART C - EXPRESS ISSUE PREMIER – COMPLETE PARTS A, B, & C

If any question in Part C is answered "Yes", the Proposed Insured is not eligible for Express Issue Premier. Submit the case as Express Issue Deluxe.

A. In the past 2 years:	
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
3. Have you been declined or postponed for Life Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. If under age 65, 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. 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 whether written by my own hand or not. I understand and agree that no information or knowledge obtained by any agent/producer, 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*****

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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/producers, 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 – Signatures

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

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

Signature of Proposed Insured or personal representative (Must be signature of Proposed Insured for Guaranteed Issue Whole Life)

Description of personal representative's authority to act

Signature of Owner (If other than Proposed Insured)

Signature of Spouse (where required in community property states when a person other than the Owner's spouse is named as Primary Beneficiary with a Share % greater than 50)

SECTION 15 – Agent's/Producer'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 _____ X _____
Printed Agent/Producer Name Agent's/Producer's Signature

Agent/Producer Code _____ Agent's/Producer's E-Mail _____

Agent/Producer: 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/producer 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/Producer 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.

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.

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. 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.
<p>1. Draft my account for the first premium (check one):</p> <p><input type="checkbox"/> Immediately upon receipt of the application in the Home Office.</p> <p><input type="checkbox"/> On the date of issue (policy date).</p> <p><input type="checkbox"/> On _____ (month & day). Choose any day between the 1st and the 28th.</p> <p><input type="checkbox"/> On the [<input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th] (check one) Wednesday of _____ (month).</p> <p><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.</p> <p>2. Unless indicated below all subsequent premiums will be drafted on the same day each month as the first premium.</p> <p style="padding-left: 20px;">Draft subsequent premiums on the _____ (1st – 28th) day of each month.</p>

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

Name of Insured	Policy Number
Requested draft day _____ (1 st – 28 th) OR the [<input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd <input type="checkbox"/> 4 th] (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#
--------------------------	------	------	----------

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 REGARDING REPLACEMENT OF INSURANCE
(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one – or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

Statement To Applicant By Insurance Producer: (Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

- 1. Can there be reduced benefits or increased premiums in later years?
2. Are there penalties, set up or surrender charges for the new policy?
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?
4. Are there adverse tax consequences from the replacement under current tax law?
5. a) Are interest earnings a consideration in this replacement? b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings.
6. Are minimum amounts required to be on deposit before excess interest will be paid?
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
a) Are the interest rates quoted before ___ or after ___ fees and mortality charges have been deducted?
b) Interest rates are guaranteed for how long?
c) The minimum interest rate to be paid is how much?
d) If applicable, the rate you pay to borrow is ____, and the limit on the amount that can be borrowed is _____.
e) The surrender charges are _____.
f) The death benefit is _____.
8. Are there other short or long term effects from the replacement that might be materially adverse?

Signature of Insurance Producer

Date

Name of Insurance Producer (Print or Type)

Address

City State

List of Policies or Contracts to be Replaced:

<u>Company</u>	<u>Insured</u>	<u>Contract No.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Caution: The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing insurance producer or company. Such advice might be helpful.
- Study the comments made above by the insurance producer. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: _____
(Applicant's Signature) (Date)

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.



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

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4. Are there adverse tax consequences from the replacement under current tax law?
5. a) Are interest earnings a consideration in this replacement? b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings.
6. Are minimum amounts required to be on deposit before excess interest will be paid?
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
a) Are the interest rates quoted before ___ or after ___ fees and mortality charges have been deducted?
b) Interest rates are guaranteed for how long?
c) The minimum interest rate to be paid is how much?
d) If applicable, the rate you pay to borrow is ____, and the limit on the amount that can be borrowed is _____.
e) The surrender charges are _____.
f) The death benefit is _____.
8. Are there other short or long term effects from the replacement that might be materially adverse?

Signature of Insurance Producer

Date

Name of Insurance Producer (Print or Type)

Address

City State

List of Policies or Contracts to be Replaced:

<u>Company</u>	<u>Insured</u>	<u>Contract No.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing insurance producer or company. Such advice might be helpful.
- Study the comments made above by the insurance producer. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: _____
(Applicant's Signature) (Date)

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.



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

IMPORTANT NOTICE REGARDING REPLACEMENT OF INSURANCE
(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one – or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

Statement To Applicant By Insurance Producer: (Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

- 1. Can there be reduced benefits or increased premiums in later years?
2. Are there penalties, set up or surrender charges for the new policy?
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?
4. Are there adverse tax consequences from the replacement under current tax law?
5. a) Are interest earnings a consideration in this replacement?
b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings.
6. Are minimum amounts required to be on deposit before excess interest will be paid?
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
a) Are the interest rates quoted before ___ or after ___ fees and mortality charges have been deducted?
b) Interest rates are guaranteed for how long?
c) The minimum interest rate to be paid is how much?
d) If applicable, the rate you pay to borrow is ____, and the limit on the amount that can be borrowed is _____.
e) The surrender charges are _____.
f) The death benefit is _____.
8. Are there other short or long term effects from the replacement that might be materially adverse?

Signature of Insurance Producer

Date

Name of Insurance Producer (Print or Type)

Address

City State

List of Policies or Contracts to be Replaced:

<u>Company</u>	<u>Insured</u>	<u>Contract No.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Caution: The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing insurance producer or company. Such advice might be helpful.
- Study the comments made above by the insurance producer. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: _____
(Applicant's Signature) (Date)

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.