

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY




ARKANSAS – 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)

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.



LAP1163_AR_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					
IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS, 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? (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? (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 <input type="checkbox"/> Yes <input type="checkbox"/> No <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? (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? (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? (d) advised to receive or have received an organ or bone marrow transplant? (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 twelve (12) months?					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
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? (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 <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

<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, incarcerated for 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>

OPTIONAL COMMENTS (Not Required) - Provide any additional information available.	
Question Number	Details to Underwriting Questions (Diagnosis, Dates, Durations, Medications, Dosages)



PLAN INFORMATION

Plan:

Level Benefit Product

Amount Applied For \$ _____

Rider:

Accidental Death Rider

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

AGREEMENT

- The undersigned agree(s) that (a) all answers in this application are true and complete to the best of my knowledge and belief; (b) United of Omaha Life Insurance Company ("United of Omaha") will rely on these answers to determine insurability; and (c) incorrect or misleading answers may void this application and any issued policy effective the issue date.
- The undersigned acknowledge(s) that United of Omaha may require medical records, an underwriting assessment, a medical examination, or other information.
- The undersigned agree(s) that United of Omaha will not issue a policy as a result of this application unless (a) the Proposed Insured completes all medical examinations and tests required by United of Omaha; (b) United of Omaha receives any additional information requested for underwriting; and (c) the Proposed Insured is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the Proposed Insured or the Applicant (if other than the Proposed Insured) has subsequently accepted an offer by United of Omaha for coverage other than as applied for, according to the underwriting standards of United of Omaha then in force.
- The undersigned agree(s) that this application does not provide temporary or interim insurance prior to policy issuance. If the undersigned has made an advance premium payment, undersigned agree(s) to the terms and conditions of the Conditional Receipt. The undersigned agree(s) that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. The undersigned acknowledge(s) that if this application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to the Proposed Insured or the Applicant (if other than the Proposed Insured), without interest. No insurance coverage will be in effect until United of Omaha (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
- A completed and signed application will become part of the Proposed Insured's policy or the Applicant's policy (if other than the Proposed Insured).
- The undersigned acknowledge(s) that no producer can (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.



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 have received the MIB, Inc. Pre-Notice, the Notice of Information Practices and a Life Insurance Buyer's Guide before completing this application.

I approve the answers to the questions in this application as recorded.

I have read and understand the Authorization to Receive Information form and Disclose Information to MIB, Inc. and the Agreement Section.

Signed at: _____
City State

Date: _____

Signature of Proposed Insured

Date: _____

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

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.

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

Has the Proposed Insured informed you, the Producer(s), that he/she has any pending applications or existing life insurance or annuity contracts with the company or any other company? Yes No

(If either question is answered "Yes," fulfill all state and company requirements.)

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

If "Yes," state relationship _____

How long have you known the Proposed Insured? _____

How long have you known the Proposed Owner? _____

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



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 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

3 I conducted said interview in person Yes No

If "No," please explain _____

4 List any additional information or comments below:



UNITED OF OMAHA LIFE INSURANCE COMPANY

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



PAYMENT AUTHORIZATION FORM

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

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

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

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

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

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

PAYMENT INFORMATION FOR ONGOING PAYMENTS- AUTOMATIC BANK ACCOUNT DEDUCTION

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

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

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

PAYOR INFORMATION

Name of payor as shown on bank account: _____

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

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

PAYOR ACCOUNT INFORMATION

1. Account Type (check one): Checking Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check here.
Bank Routing Number: _____ Bank Account Number: _____
(Do not use Debit/Credit Card numbers)

Memo _____	Signed By: _____	
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



AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB Inc., state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me and my children, if they are proposed insureds (My Children), to release Personal Information about me or My Children to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

The Personal Information will be used to determine my and My Children's eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual, or its reinsurers, to disclose my and My Children's personal Information to MIB, Inc. I understand that my and My Children's Personal Information received by MIB, Inc. may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

I understand that if the person or entity to whom Personal information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I understand if I refuse to sign, the insurance for which I am applying will not be issued.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Proposed Insured acknowledges and agrees that if there is more than one Proposed Insured on this application, all information provided may be reviewed or shared with the other Proposed Insured. A completed and signed application will become part of each insured's policy.

Name(s) used for medical records (if different than the name) below: _____

Signature of Proposed Insured

Date: _____
Mo Day Yr

Signature of Spouse (if Proposed Insured)

Date: _____
Mo Day Yr

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

Date: _____
Mo Day Yr

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

Date: _____
Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS



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.
----------------	--

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>
-------------------	--

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.
-----------------	--

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>
-------------------	---

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
---	---------------	---	---------------



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.

CONDITIONS Conditions under which a benefit may be payable under this Receipt prior to policy delivery:

- 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.

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.

END DATE This Receipt and any coverage provided hereunder will **END** on the earliest of the following dates:

- 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.

SIGNATURES 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.

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.

Signature of Proposed Insured _____ Date _____

Signature of Other Proposed Insured _____ Date _____

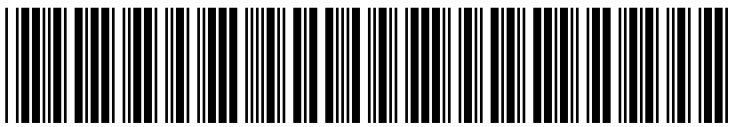
Signature of Applicant/Owner (if other than Proposed Insured) _____ Date _____

Payment Method: Check Electronic Transaction Authorization Amount remitted/authorized \$ _____

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.

Signature of Producer _____ Date _____

Signature of Producer _____ Date _____



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
---	---------------	---	---------------



Disclosure Form For Arkansas



(Producer must complete Part I or Part II of this Form. Complete Part III of this form only if applicable)

Part I.

- I represent **the insurance company or companies** indicated below with regard to the sale of its product(s). I am providing you services on behalf of the insurance company(ies) indicated below. I will receive compensation from the company or companies indicated below, for the product(s) you purchase.
 - Mutual of Omaha Insurance Company
 - United of Omaha Life Insurance Company, an affiliate of Mutual of Omaha
 - United World Life Insurance Company, an affiliate of Mutual of Omaha

Part II.

- I represent you, **the customer**, with regard to this sale. I will receive compensation from the company(ies), persons or entities indicated below, for the product(s) you purchase.
 - Mutual of Omaha Insurance Company
 - United of Omaha Life Insurance Company, an affiliate of Mutual of Omaha
 - United World Life Insurance Company, an affiliate of Mutual of Omaha
 - Customer
 - Other _____

Part III.

See instructions to determine if the producer is required to complete Part III.

Will the producer or his or her affiliate receive compensation for the policy or contract placement from the insurer or other third party based on volume, profitability, or other factors?

- Yes
- No

Print Name of Producer

Producer's Signature

Date

Acknowledged By:

Customer Name

Customer Signature

Date

ARKANSAS INSTRUCTIONS – begin using immediately.

Arkansas law now requires producers to make certain disclosures to an insurance customer at the time of sale. Disclosures are required for all product lines. For your convenience, we have created a Disclosure Form that you may use. The disclosures must be completed at the time of taking the product application. We recommend that you use this or an alternative form and keep a completed copy of it in your files. After the initial disclosure is made, no disclosure needs to be made at renewal unless the information previously disclosed has substantially changed.

You must complete either Part I or Part II of the form. Complete Part I of the form if you represent the **insurer** with regard to the sale. Complete Part II of the form if you represent the **customer** with regard to the sale. The disclosures set forth in Part III of the form must be made by a producer who (a) receives compensation from the customer for the placement of insurance, or (b) acts as a broker as defined by Arkansas law. Arkansas law defines a “broker” as an individual, firm, limited liability company, or corporation who is required to be licensed as an insurance producer under Arkansas Code section 23-64-501 *et seq.* who represents insureds or prospective insureds other than himself or herself and not on behalf of an insurer or agent.

If you are required to make the disclosures set forth in Part III of the form and the customer requests it, you must provide a reasonable estimate of the amount of compensation you or your affiliate will receive (there is extra space provided on the form for this information). If requested by the customer, the following is an example of a response that may be appropriate (you must provide a response that is appropriate for you), “For the sale of this policy, I estimate being paid _____ in first year commission. In future years, I may receive additional compensation of approximately _____ for each year that renewal premium is paid on this policy. If I reach certain sales volume levels, I may also receive other non-cash compensation such as an incentive trip.”

For purposes of this question, Arkansas law defines “affiliate” as a person that controls, is controlled by or is under common control with the producer. For purposes of this question, “compensation” means payments, commissions, fees, overrides, bonuses, contingent commissions, loan, stock options, or any other form of valuable consideration, whether or not payable pursuant to a written agreement. “Compensation” also includes awards, gifts, and prizes if they are directly tied to the producer’s performance. Please be sure to include any first year and renewal commission, bonus opportunity, incentive travel opportunity, etc.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Replacement of Life Insurance or Annuities

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older—are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

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

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?





LIFE APPLICATION SUBMISSION FORM

Send to: Individual Life Underwriting
United of Omaha Life Insurance Company
9330 State Hwy 133
Blair, NE 68008

Comments: _____

Name of Insured

Name of Agent	Production Number	Phone Number	Email Address

Next Highest Upline	Production Number	Phone Number	Email Address

Please list any underwriting requirements that have already been ordered by the agent or Master General Agent/Broker General Agent.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

LIFE INSURANCE AND ANNUITIES EXISTING CONTRACT/POLICY

Owner / Annuitant(s) _____
 Insurer _____
 Contract # _____
 Product Type * _____
 Product Name _____

REPLACEMENT MEMORANDUM PROPOSED CONTRACT/POLICY

Owner / Annuitant(s) _____
 Insurer _____
 Application # _____
 Product Type * _____
 Product Name _____

FOR BOTH LIFE INSURANCE AND ANNUITIES (Complete all that is applicable)

CONTRACT OR POLICY PROVISION	EXISTING CONTRACT/POLICY	REPLACEMENT CONTRACT/POLICY
Current Proposed Premium/ Annual Consideration		
Current Contract Value		
Current Surrender Value		
Death Benefit Amount		
Current Interest Rate & Guarantee Period		
Guaranteed Minimum Accumulation/Interest Rate		

* Deferred Fixed Annuity, Deferred Variable Annuity, Deferred Indexed Fixed Annuity, Immediate Annuity, Indexed Life Insurance, Variable Life Insurance, Whole Life Insurance, Universal Life insurance, Term Life Insurance and Endowment

Surrender Charge Period in Years/ Charge Percentage Per Year/ Years Remaining		
Are free withdrawals available? If yes, what percentage? List options.		
Other significant policy or contract provisions		

FOR ANNUITIES ONLY (Complete all that is applicable)

CONTRACT PROVISION	EXISTING CONTRACT/POLICY	REPLACEMENT CONTRACT/POLICY
Initial Bonus Percentage or Amount		
Potential Loss of Bonus if Annuity is Exchanged, Surrendered or Funds Withdrawn		
Sub-Account Choices		
Guaranteed Purchase/Settlement Options		

I have received a copy of this completed form.

_____/_____
 Owner/Annuitant Date

_____/_____
 Joint Owner/Annuitant Date

I certify that the above provisions, and any other significant provisions, of the existing policy or contract and the proposed policy or contract were discussed with the applicant(s).

_____/_____
 Producer Signature Date



UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

LIFE INSURANCE AND ANNUITIES EXISTING CONTRACT/POLICY

Owner / Annuitant(s) _____
 Insurer _____
 Contract # _____
 Product Type * _____
 Product Name _____

REPLACEMENT MEMORANDUM PROPOSED CONTRACT/POLICY

Owner / Annuitant(s) _____
 Insurer _____
 Application # _____
 Product Type * _____
 Product Name _____

FOR BOTH LIFE INSURANCE AND ANNUITIES (Complete all that is applicable)

CONTRACT OR POLICY PROVISION	EXISTING CONTRACT/POLICY	REPLACEMENT CONTRACT/POLICY
Current Proposed Premium/ Annual Consideration		
Current Contract Value		
Current Surrender Value		
Death Benefit Amount		
Current Interest Rate & Guarantee Period		
Guaranteed Minimum Accumulation/Interest Rate		

* Deferred Fixed Annuity, Deferred Variable Annuity, Deferred Indexed Fixed Annuity, Immediate Annuity, Indexed Life Insurance, Variable Life Insurance, Whole Life Insurance, Universal Life insurance, Term Life Insurance and Endowment

Surrender Charge Period in Years/ Charge Percentage Per Year/ Years Remaining		
Are free withdrawals available? If yes, what percentage? List options.		
Other significant policy or contract provisions		

FOR ANNUITIES ONLY (Complete all that is applicable)

CONTRACT PROVISION	EXISTING CONTRACT/POLICY	REPLACEMENT CONTRACT/POLICY
Initial Bonus Percentage or Amount		
Potential Loss of Bonus if Annuity is Exchanged, Surrendered or Funds Withdrawn		
Sub-Account Choices		
Guaranteed Purchase/Settlement Options		

I have received a copy of this completed form.

_____/_____
 Owner/Annuitant Date

_____/_____
 Joint Owner/Annuitant Date

I certify that the above provisions, and any other significant provisions, of the existing policy or contract and the proposed policy or contract were discussed with the applicant(s).

_____/_____
 Producer Signature Date

