

# FINAL EXPENSE WHOLE LIFE

**Regular Mail:**

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

**FAX Number: 317-692-7711**

**Telephone: 800-428-3001**

**Overnight Mail:**

United Farm Family Life Insurance  
Company  
225 South East St  
Indianapolis, IN 46202

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

**Fax only once.**

Agt Name: _____	Agt #: _____
Agt Phone: _____	Agt Fax: _____
Agt 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 <input type="checkbox"/> US Mail	
Street _____ City _____ State _____ Zip Code _____	
<b>Proposed Insured's Name:</b> _____	
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 proposed owner and/or 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"/> Telephone <input type="checkbox"/> Internet <input type="checkbox"/> Fax <input type="checkbox"/> Other _____ (Explain)	
Did you identify any unusual behavior or suspicious activity by the proposed owner or insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please explain. _____ _____	
<b>You must provide the proposed insured the attached Notice of Insurance Information Practices before submitting the application.</b>	
<b>Special Instructions you want us to know:</b> _____ _____ _____ _____	

**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 UFFL 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:** UFFL will order the PHI after you've completed the application with your client and submitted it to the Home Office. A PHI is required for all 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. Print legibly in English.
2. Keep original app until policy is issued.
3. If faxing, keep fax confirmation message that fax was successful.
4. UFFL products use the "age nearest birthday" method for determining the age of the proposed insured for insurance purposes.
5. If the replacement question is answered "Yes," ensure that the applicable replacement form(s) has been completed and included (if required).
6. Cash is not permitted for the payment of premium(s).
7. The Fair Credit Reporting Act/MIB Notice and, if applicable, the Notice of Insurance Information Practices must be given 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.



United Farm Family Life Insurance Company  
225 South East Street  
P.O. Box 7192  
Indianapolis, IN 46207-7192

## Notice of Insurance Information Practices

### Information Collected

We may collect personal information from you and from persons other than you. Depending upon the circumstances, the sources and types of personal information we collect about you may include information we receive:

- From you on your applications or other forms, such as name, address, Social Security number, birth date, assets and income.
- From consumer-reporting agencies such as credit history, credit worthiness and public records.
- About your transactions and experience with us, such as products purchased, your policy values and payment history.
- From insurance support organizations, such as MIB, about your insurability received in a coded form.
- From pharmacy records.
- From your health care providers such as copies of your medical records.
- From your employers about your occupation and earnings.
- From family members and others who may have knowledge about your character, habits and lifestyle.
- From other insurers, reinsurers or financial institutions such as other insurance coverage applied for or in force and account information.
- From governmental agencies such as a motor vehicle report.

### Information Collection Techniques

Techniques that may be used to collect information about you include:

- Personal or telephone interview
- Written correspondence
- Examination or assessment
- Investigative consumer report
- Coded reports from MIB

### Sharing Information With Others

As required or permitted by law, we may disclose all the information we have about you as follows:

- To others to enable them to perform services for us or on our behalf to underwrite insurance, process transactions and administer claims.
- To health care providers to verify insurance coverage or benefits; inform you of medical history you may not be aware of; and to verify medical treatment or services.
- To an insurance regulatory authority to comply with audits and to respond to complaints.
- To a law enforcement or other governmental authority to protect us against perpetration of fraud or other illegal activities.
- To organizations conducting actuarial or research studies; however, no individually identifiable medical information is disclosed.
- To our affiliates to provide you with better customer service and account maintenance; to help you make decisions about your products, services and benefits; and to inform you of other products, services and benefits that may be of interest to you.

We may disclose identifying information we have about you, such as name, address and telephone number with approved organizations to market products or services that may be of interest to you.

### Access to Recorded Personal Information

You have the right to access recorded personal information we have about you that you can describe and that we can reasonably locate and retrieve. This right does not extend to information about you that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving you. You also have the right to know the specific reasons for an adverse underwriting decision.

If you submit a written request to us describing the recorded information you want to access or requesting the reason for the adverse action decision, we shall do the following within thirty (30) business days from the date the request is received:

1. Inform you of the nature, substance and source of your recorded personal information or the reason for the adverse underwriting decision in writing;
2. Permit you to see and copy, in person, your recorded personal information or to obtain a copy of your recorded personal information by mail, whichever you prefer. If the recorded personal information is in coded form, an accurate translation in plain language shall be provided in writing. However, where permitted by law, copies of your medical information will be supplied to a medical provider designated by you and licensed to provide medical care with respect to the condition to which the information relates.
3. Disclose to you the identity, if recorded, of those persons to whom we disclosed your personal information within two (2) years prior to your request, and if the identity is not recorded, the names of those persons to whom such information is normally disclosed; and
4. Provide you with a summary of the procedures by which you may request correction, amendment or deletion of recorded personal information.

We may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to you.

### **Correction, Amendment or Deletion of Recorded Personal Information**

If you want to correct, amend or delete the recorded personal information we have about you, submit a written request to us. Within thirty (30) business days from the date of receipt of a written request, we will either:

1. Correct, amend or delete the portion of the recorded personal information in dispute; or
2. Notify you of our refusal to make such a correction, amendment or deletion; the reason for the refusal; your right to file a statement stating what you think is the correct, relevant or fair information; and the reasons why you disagree with our refusal to correct, amend or delete the recorded personal information.

If we correct, amend or delete recorded personal information, we will provide written notification to:

- Any person specifically designated by you who may have, within the preceding two (2) years, received such recorded personal information;
- MIB;
- Any insurance support organization whose primary source of personal information is from insurance institutions and to whom we disclosed personal information within the preceding seven years, such as MIB, Inc.; and
- Any insurance support organization that furnished the personal information that has been corrected, amended or deleted.

If we refuse to correct, amend or delete your recorded personal information and you disagree, you have the right to file a concise statement with us that sets forth what you think is the correct, relevant or fair information; and the reasons why you disagree. In the event you file a statement, we will provide access to your statement with the disputed information to anyone reviewing it, and include it in any subsequent disclosures.

### **Access to and Correction, Amendment or Deletion of Recorded Personal Information from MIB**

We may provide information about your insurability in coded form to MIB, formerly known as Medical Information Bureau, a nonprofit membership association of life insurers. MIB is a leading provider of information and database management services to its member insurers. It operates as a confidential information exchange on behalf of its member insurers.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have about you. If you question the accuracy of information in MIB's records, you may contact them. A correction may be sought in accordance with the Federal Fair Credit Reporting Act. You may contact MIB by:

Writing to: MIB, Inc.  
50 Braintree Hill Park  
Suite 400  
Braintree, MA 02184-8734

Telephoning: 866-692-6901 (TTY 866-346-3642 for hearing impaired)

Going to: [www.mib.com](http://www.mib.com)

Information obtained from a report prepared by MIB may be retained by MIB and disclosed to other persons.

# Application for Life Insurance

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

## SECTION 1 – Proposed Insured

Last Name		First Name		Middle Initial
Date of Birth (M-D-Y)	State of Birth	<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				
City	State	Zip Code	Phone Number ( )	

Employer/Occupation/Duties/How Long There (Required)

Billing Street Address	City	State	Zip Code		
Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code

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

Owner Name	Relationship	Social Security Number	
Owner Street Address	City	State	Zip Code
Contingent Owner Name	Relationship	Social Security Number	

## SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name	Relationship	Age
Contingent Beneficiary Name	Relationship	Age

## SECTION 4 – Plan of Insurance

Plan of Insurance <input type="checkbox"/> Graded Death Benefit Endowment (Guaranteed Issue) <input type="checkbox"/> Express Issue Whole Life <input type="checkbox"/> Express Issue Deluxe <input type="checkbox"/> Express Issue Premier <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: Identity Theft Waiver of Premium Rider, Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

Accidental Death Benefit Rider (not available with Graded Death Benefit Endowment or Express Issue WL) \$ \_\_\_\_\_

## SECTION 5 – Payment Information

Modal Premium:  Annual  Semi-Annual  Qtrly.  PAC\* Modal Premium Amount \$ \_\_\_\_\_  
\$ \_\_\_\_\_ paid with application.

\*If selected, bank information on Page 5 must be fully completed.

## SECTION 6 – Other Insurance

Do you have any existing life insurance policies or annuity contracts?  Yes  No  
If "Yes," please complete any necessary replacement forms.

## SECTION 7 – Nicotine Use

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

## SECTION 8 – Physician Information

Name and Address of Family Physician (Required)	Family Physician Telephone Number (Required) ( ) -
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**SECTION 9 – Medical Questions**

If the plan selected in Section 4 is the Graded Death Benefit Endowment, the Proposed Insured should not answer the health questions below.

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

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 for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of HIV antibodies, antigens, or the virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. <b>In the past twelve (12) months:</b>	
1. Other than for temporary or minor conditions, 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**

A. <b>In the past 2 years:</b>	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer's Disease or Dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. 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) 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 (except for 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. <b>In the past 10 years</b> have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

A. <b>In the past 2 years:</b>	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes requiring insulin treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. SLE (Systemic Lupus Erythematosus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 any hazardous sport or aviation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION 10 – 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 that my policy will not be effective until the date it is issued by the company and the premium paid.

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

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

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud, which is a crime.

I, the Proposed Owner, and Proposed Insured (if other than Proposed Owner), hereby certify under penalties of perjury, that the tax identification number provided is true, correct and complete.

## SECTION 11 – Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., that has information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children, if they are to be insured, or our health, to give the United Farm Family Life Insurance Company ("UFFL") or its reinsurer(s) any such information to determine eligibility for insurance as applied for in this application. UFFL may also disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for UFFL or as may otherwise be legally allowed. 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 UFFL may require that I submit to an HIV (HTL VIII) Screen. Prior to submitting to an HIV (HTL VIII) Screen I must be provided and sign a separate Notice and Consent for Oral Fluid and/or Blood Testing form.

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, with the exception of HIV-related information. In the case of HIV-related information, this release may be used for any legitimate insurance purpose for up to 180 days from the date below. I or my authorized representative have a right to receive a copy of this authorization.

## SECTION 12 – HIPAA Authorization

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

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

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

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

This authorization shall remain in force for 24 months following the date of my signature below, with the exception of HIV-related information. In the case of HIV-related information, this authorization may be used for any legitimate insurance purpose for up to 180 days from the date below. A copy, image, or facsimile of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Farm Family Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that United Farm Family Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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

## SECTION 13 – Signatures

**Signature applies to Sections 1 through 12. 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 Graded Death Benefit Endowment)

Description of personal representative's authority to act

Signature of Owner (If other than Proposed Insured)

**THE FOLLOWING SECTION MUST BE COMPLETED BY THE AGENT.**

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

If the application is being submitted for the Graded Death Benefit Endowment, I hereby affirm that I was personally present with the Proposed Insured when this 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.

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

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

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

AUTHORIZATION TO HONOR CHECKS  
DRAWN BY THE UNITED FARM FAMILY LIFE INSURANCE COMPANY, Indianapolis, Indiana

The initial modal premium **must** be quoted in Section 5 of the application.  
We do not accept debit or credit cards.

**Please select ONLY one option. Include a copy of voided check for bank draft.**

- Draft my account for the first premium (initial premium may be drafted immediately upon submission of this application). Please draft subsequent premiums on the \_\_\_\_\_ day of each month.
  
- Draft my account for the first premium on: \_\_\_\_\_ . All subsequent drafts will occur on this same day each month.
  
- Do NOT draft my account for the first premium. The initial premium is attached, is being mailed, or will be collected on delivery. **Please make check or money order payable to United Farm Family Life Insurance Company.** Do not leave Payee blank or make it payable to the agent. Please draft subsequent premiums on the \_\_\_\_\_ day of each month.

The policy may be placed on direct quarterly mode temporarily if we do not receive complete bank information or if there is a difference in premium quoted.

**I understand that my policy will not be effective until the policy is issued and premium paid.**

Bank Name \_\_\_\_\_ Bank Address \_\_\_\_\_

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Farm Family Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that I am personally liable for overdraft fees charged on said account if funds are not available at the designated date of withdrawal. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry. I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account Number: \_\_\_\_\_  Checking  Savings Routing Number: \_\_\_\_\_

Premium Payor's Printed Name: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Signature of Premium Payor: \_\_\_\_\_ Date: \_\_\_\_\_

**In the event that a pre-printed void check or bank statement is not available, please complete the following information for account verification:**

Financial Institution: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

I have personally verified that the above policy owner/payor has a current, active account.

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

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE DETACH AND GIVE TO APPLICANT**

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

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

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

**I understand that my policy will not be effective until the date it is issued by the company.**

**RECEIPT**

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

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

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

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

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

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

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

In compliance with Public Law 91-508, this notice is to inform you that in connection with your application for insurance (1) an investigation may be made, and information collected from persons other than you, as to your insurability, including, if applicable, information as to character, general reputation and personal characteristics; (2) this information as well as other personal or privileged information subsequently collected by United Farm Family Life Insurance Company or the agent may in certain circumstances be disclosed to third parties without authorization; (3) if you question the accuracy of the information collected you may contact us and seek a correction; and (4) the notice required by Arizona Statute 20-2104(B) will be furnished to you, upon your written request made within a reasonable time after you receive this notice. You may request to be personally interviewed in connection with the preparation of the investigation and to receive a copy of the report.

Information regarding your insurability will be treated as confidential. United Farm Family Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-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 (TTY 866-346-3642 for hearing impaired).

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

I declare that I have read and understand the above notice.

**IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION**

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



UNITED FARM FAMILY LIFE INSURANCE COMPANY

P.O. Box 7192

Indianapolis, IN 46207-7192

Phone: (317) 692-7979 Fax: (317) 692-7711

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions.

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

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

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (including the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Table with 4 columns: Insurer Name, Contract Or Policy #, Insured Or Annuitant, Replaced (R) Or Financing (F). Rows 1, 2, 3.

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

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

Applicant's Signature and Printed Name Date

Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)

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

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

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

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

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

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

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

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

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



UNITED FARM FAMILY LIFE INSURANCE COMPANY

P.O. Box 7192

Indianapolis, IN 46207-7192

Phone: (317) 692-7979 Fax: (317) 692-7711

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