



APPLICATION for CHILD RIDER

United Home Life Insurance Company

P.O. Box 7192

Indianapolis, IN 46207-7192

1-800-428-3001

United Home Life Insurance Company

Child Rider Application

Application is hereby made for Child Rider to be provided by supplementary provision or agreement attached to and made part of

Any policy to be issued on application dated _____ }
 Policy No. _____ } on the life of (hereinafter referred to as Insured)

1. Full name of children of Insured, including legally adopted children and stepchildren, who are under age 19	Relationship to Insured	Date of Birth*	Place of Birth (State or Country)	Ht.	Wt.

***PLEASE NOTE: No coverage is afforded infants under 30 days.**

2. Child Rider Amount \$5,000 \$10,000 \$15,000 \$20,000 *Total amount of Child Rider coverages cannot exceed \$20,000*

3. In the past 5 years has any child named in Question 1 had: Any consultation or treatment by any physician or practitioner; examination in a clinic, hospital, dispensary, or sanitarium; any disease, ailment, injury or complaint which caused loss of time from school or work; any surgical operation, x-ray, electrocardiogram or other special tests, or been told there is a need for them?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
4. During entire lifetime has any child named in answer to Question 1 had any deformity, impairment, abnormality or ailment of eyes, ears, arms, legs, brain, nervous system, heart, blood pressure, circulation, chest, lungs, digestion, kidneys, bladder or any other part of body, or been treated for a mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has any child named in answer to Question 1 been declined, postponed, limited, or had a policy issued other than as applied for on any life or health insurance or reinstatement thereof?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the insurance applied for intended to replace any insurance in this or any other company?	<input type="checkbox"/>	<input type="checkbox"/>

7. Give full details to questions requiring additional explanation.

**Insured's Supplementary Statements and Certificate of Health
 (Complete only if this is an addition to an existing policy)**

1. Exact Height-Weight _____ Ft. _____ In. _____ Lbs. Has weight changed more than 10 lbs in past year? If yes, amount of increase _____ decrease _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Since the date of the original application has the Insured had: Any consultation or treatment by any physician or practitioner; examination in a clinic, hospital, dispensary, or sanitarium; any surgical operation, x-ray, electrocardiogram, or other tests, or been told there is a need for them?	<input type="checkbox"/>	<input type="checkbox"/>
3. Name of physician Insured last consulted: _____ Address _____ Why consulted _____ Give name and address of family physician if different from above _____		
4. Has Insured ever: Been exempted, or discharged as unfit, from military service; applied for or received any kind of disability compensation; or had an application for life or health insurance declined, postponed, limited, or issued other than as applied for?	<input type="checkbox"/>	<input type="checkbox"/>

5. Give full details to questions requiring additional explanation.

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on this application are true to the best of my knowledge and belief. I understand that my policy will be effective on the date it is issued by the company.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or the Medical Information Bureau, 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 dependents, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I acknowledge that the information obtained by this authorization will be used by United Home Life Insurance Company to determine eligibility for insurance as applied for in this application. I understand that I am giving permission to release medical information which may include treatment or physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company 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 the contract is issued. You are entitled to receive a copy of this authorization.

*****WARNING*****

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

\$ _____ paid with application.

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

X _____ X _____
Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

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

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent E-mail _____

Agent: Phone # _____ Fax# _____ License Identification Number () _____
State

If you do not receive your Policy within 60 days from the date of your application, please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192
***Check or money order must accompany. All premium checks must be made payable to United Home Life Insurance Company.**
Do not make check or money order payable to the agent or leave the Payee blank.

200-359 3-02 (CA)

**PLEASE DETACH AND GIVE TO APPLICANT
FAIR CREDIT REPORTING ACT/MEDICAL INFORMATION BUREAU NOTICE**

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the 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 Bureau company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical Information will be disclosed either directly to the individual or to a medical professional, whichever the individual prefers.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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

200-359 3-02 (CA)

