APPLICATION
for
CHILD RIDER

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

1-800-428-3001

200-359 3-02 (DC)

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*

	YES	NO
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?	☐	☐
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?	☐	☐
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?	☐	☐
6. Is the insurance applied for intended to replace any insurance in this or any other company?	☐	☐

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_____	☐	☐
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?	☐	☐

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?	☐	☐

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.

I declare that I have read and received a copy of the Fair Credit Reporting Act/Medical Information Bureau Notice.

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 or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. 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 United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

WARNING

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

$_____ 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.

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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 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, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

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.

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UNITED
HOME
LIFE™
Insurance
Company
Simplified Products - Faster Results