



# NEW BUSINESS MEMO

## TERM LIFE

**Regular Mail:**

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

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

**Telephone: 800-428-3001**

**Overnight Mail:**

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

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

Agt Name: \_\_\_\_\_ Agt # \_\_\_\_\_

Agt Phone: \_\_\_\_\_ Agt Fax: \_\_\_\_\_

Agt Email Address: \_\_\_\_\_@\_\_\_\_\_.

How do you prefer to be notified if we should need any underwriting requirements?  
 E-Mail  Fax  US Mail

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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?  Yes  No

If No, how was the application taken? Solicited by:  Mail  Telephone  Internet  
 Fax or Other \_\_\_\_\_

Did you identify any unusual behavior or suspicious activity by the proposed owner or insured?  Yes  No

If Yes, please explain. \_\_\_\_\_

**Personal History Interviews (PHIs):** You have two options:

**Option 1 (preferred option) Know Before You Go:** You, the agent, initiate a point-of-sale (POS) interview from your client's home by calling **866-333-6557**. Tell the operator this interview is for UHL and the Term Life Insurance 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.

**Option 2:** UHL will order the PHI after you've completed the application with your client. We require a PHI for all Term Life Insurance 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 below.

**Did you complete a Point of Sale Personal History Interview with your client?**  Yes  No

Non-Med Face Limits on United Home Life's Term Portfolio:						Special Instructions you want us to know:
Iss Ages	Graded Benefit	Deluxe 20	20-Year	30-Year	Term to 65	
18-45	\$25,000#	\$50,000	\$200,000	\$200,000	\$200,000	_____
46-55	\$25,000	\$50,000	\$150,000	\$150,000*	\$150,000@	_____
56-60	\$25,000	\$50,000	\$100,000	N/A	N/A	_____

# Graded Benefit Term 10 Issue Ages = 25-60 (45-60 in CA).  
 \*Issue age cannot exceed age 50 for Premier 30.  
 @Issue age cannot exceed age 50 for EIT65 and age 45 for Premier 65.  
 Check agent brochure for other tobacco issue age restrictions.

- Application Completion "Tips"**
1. Make sure to use the app with the correct state variations
  2. If Child Rider is requested, submit application 200-359
  3. If the first premium is going to be drafted from the client's bank account, *provide a copy of a pre-printed voided check!* Otherwise, the case will be unnecessarily delayed
  4. Print legibly in English
  5. Keep original app until policy is issued
  6. Keep fax confirmation message that fax was successful

**MAIL POLICY TO:**  **Applicant**  **Agent**

# Term Life Insurance Application

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

1. 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	

2. Employer/Occupation/Duties/How Long There

3.a. Primary Beneficiary Name		Relationship		Age			
3.b. Contingent Beneficiary Name		Relationship		Age			
4.a. Owner Name		Relationship		Social Security Number			
Owner Street Address			City		State	Zip Code	
4.b. Contingent Owner Name		Relationship		Social Security Number			
5. Billing Street Address			City		State	Zip Code	
Secondary Addressee (For Past Due Notice)	Name		Street		City	State	Zip Code

6.a. Plan of Insurance  Graded Benefit Term 10  Express Issue Term Deluxe 20  
 Express Issue Term +  Premier 20  Express Issue Term 30  Premier 30  Express Issue Term 65  Premier 65

6.b. Face Amount: \$ \_\_\_\_\_

6.c.  Accidental Death Benefit (not available with Graded Benefit Term 10, Premier 20, Premier 30 or Premier 65)

6.d.  Waiver of Premium (not available with Graded Benefit Term 10, EIT Deluxe 20, Premier 20, Premier 30, or Premier 65)

6.e. Modal Premium:  PAC  Quarterly  Semi-Annual  Annual  
 Modal Premium Amount \$ \_\_\_\_\_

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

8. Has the proposed insured used nicotine in any form in the past 12 months?  Yes  No

9. Name and Address of Family Physician (Required) \_\_\_\_\_ Family Physician Telephone Number (Required) \_\_\_\_\_

## SECTION I – GRADED BENEFIT TERM 10 – COMPLETE SECTION I 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 care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>D. 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

If any question in Section I is answered "Yes", you are not eligible for any plan of insurance.

## SECTION II - EXPRESS ISSUE TERM DELUXE 20 – COMPLETE SECTIONS I & II ONLY

<b>A. In the past 5 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. In the past 2 years have you been declined or postponed for Life Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. In the past 10 years have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. 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

If any question in Section II is answered "Yes", you are not eligible for Express Issue Term Deluxe 20. Submit the case as Graded Benefit Term 10.

**SECTION III – ALL OTHER TERM PLANS – COMPLETE SECTIONS I, II & III**

<b>A. In the past 5 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
B. 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

If any question in Section III is answered "Yes", you are not eligible for any of the term plans in Section III. Submit the case as Express Issue Term Deluxe 20.

**I hereby apply for the insurance indicated above and I am submitting the first premium. I represent 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.**

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

**AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., 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\*\*\***

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.

\$ \_\_\_\_\_ paid with application.

I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount. (This benefit is not available with the Graded Benefit Term 10 or Express Issue Term Deluxe 20 plans.)

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 applicant does  does not  have any existing life insurance policies or annuity contracts.

I certify that I have provided the proposed insured a copy of the Terminal Illness Accelerated Benefit Disclosure Statement and a numerical illustration.

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

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

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

**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. Include copy of voided check for bank draft.**

**AUTHORIZATION TO HONOR CHECKS DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana**

Please select **ONLY** one option, complete bank information and sign authorization below.

- Draft my account for the first premium (initial premium may be drafted upon receipt 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. *Month, Day*
- Do **NOT** draft my account for the first premium. The initial premium is attached, is being mailed or will be collected on delivery. Please draft subsequent premiums on the \_\_\_\_\_ day of each month.

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

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

TO: \_\_\_\_\_ Bank \_\_\_\_\_ 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 Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. 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 No. \_\_\_\_\_ Date \_\_\_\_\_ Bank signature of Premium Payor \_\_\_\_\_

PLEASE DETACH AND GIVE TO APPLICANT

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

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

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent 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 the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., 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 Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION**

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

**Terminal Illness Accelerated Benefit Disclosure Statement**

**(This benefit is not available with the Graded Benefit Term 10 or Express Issue Term Deluxe 20 plans.)**

**Benefits paid under this benefit may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit.**

**Description of Benefits** - This Benefit provides you with the right to access the Death Benefit (discounted at interest for one year)\* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

**Effect on the Policy** - When the accelerated benefit is paid, the policy terminates.

**Example** - This example is for illustration only, uses a \$100,000 policy and an interest rate of 7%.\* **The amounts shown are not based on your specific policy.**

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Death Benefit	\$100,000.00
Less 7%	<u>6,542.06</u>
Accelerated Benefit	<b>\$ 93,457.94</b>

\*The interest rate used to discount this benefit is defined in Section A of your Terminal Illness Accelerated Benefit Rider.



## Authorization for Release of Medical Information

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

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

\_\_\_\_\_  
Name of proposed insured/patient (**please type or print**)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

**I authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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

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

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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

\_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Patient



## Authorization for Release of Medical Information

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

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

\_\_\_\_\_  
Name of proposed insured/patient (**please type or print**)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

**I authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (“My Providers”) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. 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.

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

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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\_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative’s Authority or Relationship to Patient