



# ACCIDENTAL DEATH -NEW BUSINESS MEMO

## WHOLE LIFE PROTECTOR

### APPLICATION

Telephone: 800-428-3001

**Regular Mail:**

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

**Overnight Mail:**

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

FAX Number: 317-692-7711 \_\_\_\_\_ # pages including cover

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

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

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

Did you personally see all persons proposed for insurance, read each question to the proposed insured and record their answers?  
 Yes  No

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

Special Instructions to Agent on determining the base policy face amount:  
 To determine face amount of Whole Life Protector base policy (6.a. on p. 1 of application), choose one of these options:

	Amounts Available		
	Option 1	Option 2	Option 3
Base Coverage (6.a.)	\$125	\$188	\$250
Rider Coverage (6.b.)	\$50,000	\$75,000	\$100,000
Annual Premium	\$147.50	\$196.25	\$245.00

Special Instructions you want us to know: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

MAIL POLICY TO:  Applicant  Agent

# Whole Life Protector 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	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

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. <input type="checkbox"/> Whole Life Protector - Base Policy \$ _____	6.b. <input type="checkbox"/> Accidental Death Benefit Rider \$ _____	6.c. Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Qtrly. <input type="checkbox"/> PAC Modal Premium Amount \$ _____
--	--	--

7. Will this insurance replace or change any other insurance policies or annuities?  Yes  No *If "Yes," please provide the complete details of the insurance to be replaced, including amount, company and plan of insurance, and complete any necessary replacement forms.*

8. In the past 3 years, have you had any participation in, or contemplate any future participation in any hazardous sport or aviation, or had your drivers license suspended or revoked or in the past 5 years have you been convicted of operating a vehicle while intoxicated? **If yes, does not qualify for plan.**  Yes  No

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

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, insurance company, or the Medical Information Bureau that has records of me or my dependents' health, to give the United Home Life Insurance Company or its reinsurer(s) health information. I understand that I am giving permission to release medical information which includes treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or AIDS, or AIDS-related information. **This authorization excludes divulging whether test for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has AIDS/ARC.**

A photographic copy of this authorization shall be as valid as the original, and may be used for up to two (2) years from the date the contract is issued.

This authorization may be revoked by the owner by submitting a written request to United Home Life Insurance Company's Home Office.

Failure to sign the authorization or revoking the authorization could result in the inability of United Home Life Insurance Company to process this application.

The owner/insured has the right to a copy of this authorization and application.

### \*\*\*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.

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'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**

Draft my account for the first premium (initial premium may be drafted upon receipt of this application)

Monthly Draft Date for Subsequent Drafts: \_\_\_\_\_

**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

**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, information obtained will not be used to determine sexual orientation, 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.

*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 \_\_\_\_\_



## 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