



NEW BUSINESS MEMO

TELE-APPLICATION – PART I

PROVIDER WHOLE LIFE

Telephone: 800-428-3001

Regular Mail:

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

Overnight Mail:

United Farm Family 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: _____@_____.	
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 _____	
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 or Other _____ 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. _____ Is the proposed insured under the age of 15 and a dependent of a member of the Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please complete and submit form 18-673 7-10, Military Personnel Financial Services Disclosure Regarding Insurance Products. You must provide the proposed insured the attached Notice of Insurance Information Practices before submitting the application.	
PHI'S: We require Personal History Interviews on all Applicants for this plan of insurance. As the agent, you can initiate the interview from the client's home by calling 866-333-6557 (M-F, 8:30 a.m.-8:30 p.m. EST). Tell the operator this interview is for United Farm Family Life Insurance Company. A traditional PHI will be ordered by the Home Office if a Point of Sale PHI is not completed by you. Detailed explanation is on our website at www.unitedhomelife.com . Did you complete a POS PHI with your client? <input type="checkbox"/> Yes <input type="checkbox"/> No If we have to conduct a PHI with your client, what is the best time to reach the client? Home phone (____) _____ available days? <input type="checkbox"/> Yes <input type="checkbox"/> No Business phone (____) _____ available days? <input type="checkbox"/> Yes <input type="checkbox"/> No Cell phone (____) _____ available days? <input type="checkbox"/> Yes <input type="checkbox"/> No If a language other than English is required, please specify below.	
Special Instructions you want us to know: _____	
Application Completion "Tips"	
<ol style="list-style-type: none"> 1. Make sure to use the app with the correct state variations 2. Make sure to obtain signature of the proposed Insured age 15 and older. 3. If Child Rider is requested, submit application 18-359 4. If the first premium is going to be drafted from the client's bank account, <i>provide a copy of a voided check!</i> Otherwise, the case will be unnecessarily delayed 5. Print legibly in English 6. Keep original app until policy is issued 7. Keep fax confirmation message that fax was successful 	

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



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

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

Provider Whole Life Insurance Tele-Application – Part I

United Farm Family 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	Drivers License No. _____ State _____		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					2.a. How many hours worked per week?		
3. Beneficiary Name (for the Face Amount listed in 6.b.)				Relationship		Age	
a. Primary							
b. Contingent				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: Provider							
6.b. Face Amount: \$ _____ If this face amount is \$25,000 or greater, the Company will issue the policy with a face amount 1% higher at no additional charge. The corresponding increase in death benefit will be paid to the Charitable Gift Beneficiary you designate below.							
6.c. If the Face Amount shown above is \$25,000 or greater:							
1. List the Charitable Gift Beneficiary							
Name _____				Address _____			
(If none chosen, Charitable Gift Beneficiary will be American Red Cross.)							
2. The following benefits will be attached to the policy: Life Threatening Cancer Accelerated Benefit Rider and Common Carrier Accidental Death Benefit Rider.							
6.d. If the issue age of the proposed insured is 17 years or less, the following benefit will be attached to the policy: Guaranteed Insurability Benefit Rider.				6.e. Waiver of Premium <input type="checkbox"/>		6.f. Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Qtrly. <input type="checkbox"/> PAC Modal Premium Amount \$ _____	
7. Do you have any existing life insurance policies or annuity contracts? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please complete any necessary replacement forms.							
8. Is there, or will there be, any agreement or understanding that provides for a party, other than the Owner, to obtain any interest in any policy issued on the life of the proposed insured as a result of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No							
9. Have you:							
a. used nicotine in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate type: <input type="checkbox"/> cigarettes <input type="checkbox"/> cigar <input type="checkbox"/> pipe <input type="checkbox"/> chewing <input type="checkbox"/> snuff <input type="checkbox"/> other _____ nicotine replacement products							
b. used nicotine in any form in the past and quit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date last used? _____							

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/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 Farm Family 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 Farm Family 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.

*****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 is guilty of insurance fraud.

\$ _____ paid with application.

I understand that Part II Medical Questionnaire is a part of the application when signed by the Proposed Insured(s).

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.

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 with a numerical illustration.

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail _____

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

Please select one:

Underwriting Information:

- Standard (Juvenile Age 0-17)
- Standard Tobacco
- Standard Non tobacco
- Preferred Non tobacco

Check or money order must accompany. All premium checks must be made payable to United Farm Family 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 FARM FAMILY 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 Farm Family 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 Farm Family 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 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 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 Farm Family Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to MIB, Inc., formerly known as 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 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.

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

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	\$ 93,457.94

*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 Farm Family 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 Farm Family 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 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 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 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 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 Farm Family 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 Farm Family 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 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 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 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.

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Signature of Proposed Insured/Patient or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Patient