



# FINAL EXPENSE WHOLE 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

**Fax only once.**

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 \_\_\_\_\_

**Proposed Insured's Name:** \_\_\_\_\_

Do you personally know the proposed insured?  Yes  No

Have you written insurance on the proposed insured in the past three (3) years?  Yes  No

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  Other \_\_\_\_\_  
(Explain)

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

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MAIL POLICY TO:**  **Owner**  **Agent**

**Personal History Interviews (PHIs):**

Do **NOT** complete a PHI if the application being submitted is for the GIWL (Graded Death Benefit Endowment).

**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 EIWL (graded benefit), Deluxe or Premier 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.

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

**Option 2:** UHL will order the PHI after you've completed the application with your client and submitted it to the Home Office. A PHI is required for all EIWL, Deluxe and Premier 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 \_\_\_\_\_.**

**Important Reminders**

1. Print legibly in English.
2. Keep original app until policy is issued.
3. If faxing, keep fax confirmation message that fax was successful.
4. UHL products use the "age nearest birthday" method for determining the age of the proposed insured for insurance purposes.
5. If the replacement question is answered "Yes," ensure that the applicable replacement form(s) has been completed and included (if required).
6. Cash is not permitted for the payment of premium(s).
7. The Fair Credit Reporting Act/MIB Notice and, if applicable, the Notice of Insurance Information Practices must be given to the proposed insured. These documents must also be provided to any applicant who completes the Know Before You Go (point-of-sale) PHI process, regardless of whether an application is written or not.

# Application for Life Insurance

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

## SECTION 1 – Proposed Insured

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 ( )	

Employer/Occupation/Duties/How Long There (Required)

Billing Street Address	City	State	Zip Code	
Secondary Addressee (For Past Due Notice)	Name	Street	City	State   Zip Code

## SECTION 2 – Ownership (Complete only if Owner is other than Proposed Insured)

Owner Name	Relationship	Social Security Number		
Owner Street Address	City	State	Zip Code	
Contingent Owner Name	Relationship	Social Security Number		

## SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name	Relationship	Age
Contingent Beneficiary Name	Relationship	Age

## SECTION 4 – Plan of Insurance

Plan of Insurance <input type="checkbox"/> Graded Death Benefit Endowment (Guaranteed Issue) <input type="checkbox"/> Express Issue Whole Life <input type="checkbox"/> Express Issue Deluxe <input type="checkbox"/> Express Issue Premier	Face Amount: \$ _____
<input type="checkbox"/> Check here if you are willing to accept any product listed in this section for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit in the first 2 or 3 years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.	

If the Face Amount shown above is \$10,000 or greater and the product issued is the Express Issue Whole Life, the following riders will be attached to the policy: Identity Theft Waiver of Premium Rider, Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

Accidental Death Benefit Rider (not available with Graded Death Benefit Endowment or Express Issue WL) \$ \_\_\_\_\_

## SECTION 5 – Payment Information

Modal Premium:  Annual  Semi-Annual  Qtrly.  PAC\* Modal Premium Amount \$ \_\_\_\_\_  
\$ \_\_\_\_\_ paid with application.

**\*If selected, bank information on Page 5 must be fully completed.**

## SECTION 6 – Other Insurance

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

## SECTION 7 – Nicotine Use

Has the Proposed Insured used nicotine in any form in the past 12 months?  Yes  No

## SECTION 8 – Physician Information

Name and Address of Family Physician (Required)	Family Physician Telephone Number (Required) ( ) -
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**SECTION 9 – Medical Questions**

If the plan selected in Section 4 is the Graded Death Benefit Endowment, the Proposed Insured should not answer the health questions below.

**PART A - EXPRESS ISSUE WHOLE LIFE – COMPLETE PART A ONLY**

If any question in Part A is answered "Yes", you are not eligible for Express Issue Whole Life.

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 nursing 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? The diagnosis or treatment of AIDS must be conducted by a physician or member of the medical profession. The reporting of AIDS/HIV test results is limited only to the results of FDA-licensed tests and the consumer need not report the results of tests conducted at an anonymous counseling and testing site, or home test kit.	<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

**PART B - EXPRESS ISSUE DELUXE – COMPLETE PARTS A & B ONLY**

If any question in Part B is answered "Yes", you are not eligible for Express Issue Deluxe. Submit the case as Express Issue Whole Life.

<b>A. In the past 2 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>B. In the past 10 years</b> 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

**PART C - EXPRESS ISSUE PREMIER – COMPLETE PARTS A, B, & C**

If any question in Part C is answered "Yes", you are not eligible for Express Issue Premier. Submit the case as Express Issue Deluxe.

<b>A. In the past 2 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
3. Have you been declined or postponed for Life Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>B.</b> 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
<b>C.</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

## SECTION 10 – Agreement/Acknowledgment

I hereby apply for the insurance indicated above and I am submitting the first premium. I have read (or have had read to me) all statements and answers recorded on this application, and 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 and the premium paid.

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

\*\*\*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.

I, the Proposed Owner, and Proposed Insured (if other than Proposed Owner), hereby certify under penalties of perjury, that the tax identification number provided is true, correct and complete.

## SECTION 11 – 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, if they are to be insured, or our health, to give the United Home Life Insurance Company ("UHL") or its reinsurer(s) any such information. UHL may also disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for UHL or as may otherwise be legally allowed. 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. The diagnosis or treatment of AIDS must be conducted by a physician or member of the medical profession. The reporting of AIDS/HIV test results is limited only to the results of FDA-licensed tests and the consumer need not report the results of tests conducted at an anonymous counseling and testing site, or home test kit.

I understand that UHL may require that I submit to an HIV (HTL VIII) Screen; see Authorization Form 200-286 9-05 (WI).

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 of my signature below. I or my authorized representative have a right to receive a copy of this authorization.

## SECTION 12 – HIPAA Authorization

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

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 and its agents, employees, and representatives. United Home Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Home Life Insurance Company or as may otherwise be legally allowed. 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. The diagnosis or treatment of AIDS must be conducted by a physician or member of the medical profession. The reporting of AIDS/HIV test results is limited only to the results of FDA-licensed tests and the consumer need not report the results of tests conducted at an anonymous counseling and testing site, or home test kit.

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 24 months following the date of my signature below, and a copy, image, or facsimile 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 or my authorized representative have a right to receive a copy of this authorization.

## SECTION 13 – Signatures

**Signature applies to Sections 1 through 12. Review before signing.**

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City State Month Year

Signature of Proposed Insured or personal representative (Must be signature of Proposed Insured for Graded Death Benefit Endowment)

Description of personal representative's authority to act

Signature of Owner (If other than Proposed Insured)

**THE FOLLOWING SECTION MUST BE COMPLETED BY THE AGENT.**

To the best of my knowledge and belief the applicant does  does not  have any existing life insurance policies or annuity contracts.

If the application is being submitted for the Graded Death Benefit Endowment, I hereby affirm that I was personally present with the Proposed Insured when this application was completed, and: (1) the Proposed Insured is not confined to a hospital, hospice, nursing home, convalescent home, or does not require home health nursing care; (2) to my knowledge the Proposed Insured is not HIV+ or does not have AIDS or any terminal illness (any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months); and (3) I have no knowledge of intravenous drug abuse (IVDA) of the Proposed Insured.

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

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

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

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

The initial modal premium **must** be quoted in Section 5 of the application.  
We do not accept debit or credit cards.

**Please select ONLY one option. Include a copy of voided check for bank draft.**

- Draft my account for the first premium (initial premium may be drafted immediately upon submission 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.
  
- Do NOT draft my account for the first premium. The initial premium is attached, is being mailed, or will be collected on delivery. **Please make check or money order payable to United Home Life Insurance Company.** Do not leave Payee blank or make it payable to the agent. Please draft subsequent premiums on the \_\_\_\_\_ day of each month.

The policy may be placed on direct quarterly mode temporarily if we do not receive complete bank information or if there is a difference in premium quoted.

**I understand that my policy will not be effective until the policy is issued and premium paid.**

Bank Name \_\_\_\_\_ 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 understand that I am personally liable for overdraft fees charged on said account if funds are not available at the designated date of withdrawal. 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 Number: \_\_\_\_\_  Checking  Savings Routing Number: \_\_\_\_\_

Premium Payor's Printed Name: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Signature of Premium Payor: \_\_\_\_\_ Date: \_\_\_\_\_

**In the event that a pre-printed void check or bank statement is not available, please complete the following information for account verification:**

Financial Institution: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

I have personally verified that the above policy owner/payor has a current, active account.

Agent Name: \_\_\_\_\_ Agent #: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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.



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

## WISCONSIN NOTICE AND CONSENT FOR HUMAN IMMUNODEFICIENCY TESTING

### Request For Consent For Testing

To evaluate your insurability, United Home Life Insurance Company (Insurer) requests that you be tested to determine the presence of human immunodeficiency virus (HIV) antibody or antigens. By signing and dating this form, you agree that this test may be done and that underwriting decisions may be based on the test results. A licensed laboratory will perform one or more tests approved by the Wisconsin Commissioner of Insurance.

### Pretesting Consideration

Many public health organizations recommend that, if you have any reason to believe you may have been exposed to HIV, you become informed about the implications of the test before being tested. You may obtain information about HIV and counseling from a private health care provider, a public health clinic, or one of the AIDS service organizations on the attached list. You may also wish to obtain an HIV test from an anonymous counseling and testing site before signing this consent form. The Insurer is prohibited from asking you whether you have been tested at an anonymous counseling and testing site and from obtaining the results of such a test. **For further information on these options, contact the Wisconsin HIV/STD/Hepatitis C Information and Referral Center (IRC) hotline at 1-800-334-2437.**

### Meaning Of Positive Test Results

This is not a test for AIDS. It is a test for HIV and shows whether you have been infected by the virus. A positive test result may have an effect on your ability to obtain insurance. A positive test result does not mean that you have AIDS, but it does mean that you are at a seriously increased risk of developing problems with your immune system. HIV tests are very sensitive and specific. Errors are rare but they can occur. If your test result is positive, you may wish to consider further independent testing from your physician, a public health clinic, or an anonymous counseling and testing site. **HIV testing may be arranged by calling the IRC at 1-800-334-2437.**

### Notification Of Test Results

If your HIV test result is negative, no routine notification will be sent to you. If your HIV test result is other than normal, the Insurer will contact you and ask for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the test results.

### Disclosure Of Test Results

All test results will be treated confidentially. The laboratory that does the testing will report the result to the Insurer. If necessary to process your application, the Insurer may disclose your test result to another entity such as a contractor, affiliate, or reinsurer. If your HIV test is positive, the Insurer may report it to the Medical Information Bureau (MIB, Inc.), as described in the notice given to you at the time of application. If your HIV test is negative, no report about it will be made to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. These organizations may not disclose the fact that the test has been done or the result of the test except as permitted by law or authorized in writing by you.

### Consent

I have read and I understand this notice and consent for HIV testing. I voluntarily consent to this testing and the disclosure of the test result as described above. A photocopy or facsimile of this form will be as valid as the original.

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian, or Health Care Agent

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name of Proposed Insured (Print)

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code



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

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### Pretesting Consideration

Many public health organizations recommend that, if you have any reason to believe you may have been exposed to HIV, you become informed about the implications of the test before being tested. You may obtain information about HIV and counseling from a private health care provider, a public health clinic, or one of the AIDS service organizations on the attached list. You may also wish to obtain an HIV test from an anonymous counseling and testing site before signing this consent form. The Insurer is prohibited from asking you whether you have been tested at an anonymous counseling and testing site and from obtaining the results of such a test. **For further information on these options, contact the Wisconsin HIV/STD/Hepatitis C Information and Referral Center (IRC) hotline at 1-800-334-2437.**

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### Consent

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\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian, or Health Care Agent

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name of Proposed Insured (Print)

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip Code

## RESOURCES FOR PERSONS WITH A POSITIVE HIV TEST

**The Wisconsin HIV/STD/Hepatitis C Information and Referral Center (IRC)** hotline and website provide easily accessible information and referrals for people diagnosed with HIV, STDs, or Hepatitis C, people at risk for HIV, STDs, or Hepatitis C, and organizations that provide services to these people. People will have access to IRC information and referrals, including testing sites, through a statewide toll-free hotline and a dedicated website. To contact the IRC, call **1-800-334-2437**, on-line at [www.irc-wisconsin.org](http://www.irc-wisconsin.org), or e-mail your questions to [irc-wisconsin@arcw.org](mailto:irc-wisconsin@arcw.org). The IRC is a program of the AIDS Resource Center of Wisconsin.

**AIDS Resource Center of Wisconsin (ARCW)** provides direct support services to people living with AIDS and HIV infection. Services through ARCW's Appleton, Eau Claire, Green Bay, Kenosha, La Crosse, Milwaukee, Superior, and Wausau offices include primary medical care, medical referrals, financial assistance, housing and rent assistance, legal counsel, comprehensive case management, food and nutritional assistance, emotional support, referral for pastoral care, assistance with daily living needs, and support groups. Services through ARCW's Madison office include financial assistance, housing and rent assistance, and legal counsel. Call, visit, or write the AIDS Resource Center of Wisconsin near you or visit the website at [www.ARCW.org](http://www.ARCW.org) or e-mail your questions to [info@arcw.org](mailto:info@arcw.org).

<b>Eau Claire</b>	AIDS Resource Center of Wisconsin 505 Dewey Street South, Suite 107 Eau Claire, WI 54701 or PO Box 11 Eau Claire, WI 54702-0011 (715) 836-7710 1-800-750-2437 FAX: (715) 836-9844	Counties served: Barron, Buffalo, Burnett, Chippewa, Clark, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St. Croix, Washburn
<b>Green Bay</b>	AIDS Resource Center of Wisconsin 445 South Adams Street Green Bay, WI 54301 or PO Box 2040 Green Bay, WI 54306-2040 (920) 437-7400 1-800-675-9400 FAX: (920) 437-1040	Counties served: Calumet, Brown, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Menominee, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, Waushara, Winnebago
<b>Kenosha</b>	AIDS Resource Center of Wisconsin 1212 57th Street Kenosha, WI 53140 or PO Box 0173 Kenosha, WI 53141-0173 (262) 657-6644 1-800-924-6601 FAX: (262) 657-6949	Counties served: Jefferson, Kenosha, Racine, Walworth
<b>La Crosse</b>	AIDS Resource Center of Wisconsin 2519 South Avenue La Crosse, WI 54601 (608) 785-9866 1-800-947-3353 FAX: (608) 784-6661	Counties served: Jackson, La Crosse, Monroe, Trempealeau, Vernon
<b>Madison</b>	AIDS Resource Center of Wisconsin 121 South Pinckney Street, Suite 320 Madison, WI 53703 (608) 258-9103 1-800-518-9910 FAX: (608) 258-9136	Counties served: Adams, Columbia, Crawford, Dane, Dodge, Grant, Green, Iowa, Juneau, Lafayette, Richland, Rock, Sauk

<b>Milwaukee</b>	AIDS Resource Center of Wisconsin 820 North Plankinton Avenue Milwaukee, WI 53203 or PO Box 510498 Milwaukee, WI 53203-0092 (414) 273-1991 1-800-359-9272 FAX: (414) 273-2357	Counties served: Milwaukee, Ozaukee, Washington, Waukesha
<b>Superior</b>	AIDS Resource Center of Wisconsin Board of Trade Building 1507 Tower Avenue, Suite 230 Superior, WI 54880 (715) 394-4009 1-877-242-0282 FAX: (715) 394-4066	Counties served: Ashland, Bayfield, Douglas, Iron, Sawyer
<b>Wausau</b>	AIDS Resource Center of Wisconsin 1105 Grand Avenue, Suite 1 Schofield, WI 54476 or PO Box 26 Schofield, WI 54476 (715) 355-6867 1-800-551-3311 FAX: (715) 355-0640	Counties served: Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood

**AIDS Network** provides direct support services to people living with AIDS and HIV infection throughout the thirteen counties of south central Wisconsin. AIDS Network services include comprehensive case management services, prevention education and outreach, harm reduction counseling and testing for HIV and Hepatitis C, advocacy, legal assistance, financial and housing assistance, volunteer support, assistance with daily living needs, support groups, food pantry, dental clinic, medical and service referrals, treatment adherence, nutritional counseling, transportation assistance, and emotional and practical support. Call, visit, or go to [www.aidsnetwork.org](http://www.aidsnetwork.org) for more information.

AIDS Network offices offer comprehensive services in the following counties:

**Counties Served:** Adams, Columbia, Crawford, Dane, Dodge, Grant, Green, Iowa, Juneau, Lafayette, Richland, Rock, and Sauk

**Beloit:** AIDS Network  
136 West Grand Avenue, Suite 202  
Beloit, WI 53511  
(608) 364-4027  
1-800-486-6276  
FAX: (608) 364-0473

**Janesville:** AIDS Network  
101 East Milwaukee Street, Suite 409  
Janesville, WI 53545  
(608) 756-3010  
1-800-486-6276  
FAX: (608) 756-2545

**Madison:** AIDS Network  
600 Williamson Street, Suite H  
Madison, WI 53703  
(608) 252-6540  
1-800-486-6276  
FAX: (608) 252-6559

**Additional Resources:**

Dennis C. Hill Harm Reduction Center  
AODA Outpatient Clinic  
Dan Nowak, Coordinator  
820 North Plankinton Avenue  
Milwaukee, WI 53203  
(414) 225-1512 or  
(414) 223-6828  
1-800-359-9272  
FAX: (414) 273-2357

## THE IMPLICATIONS OF TESTING POSITIVE FOR HIV

**A positive test result is not a diagnosis of AIDS.** A positive test means that you have HIV infection. Like people with other chronic medical problems, people with HIV infection have a spectrum of conditions, ranging from no symptoms to very serious ones. Over time, most people with HIV infection progress along the spectrum toward more serious symptoms. **However, both improved medical management and many options for self-care now provide new hope for people with HIV infection.** Anti-viral drug therapy and preventive antibiotics can delay progression of HIV infection and postpone or modify complications.

**It is extremely important to find a knowledgeable, experienced, and supportive health care provider to work with you in evaluating and managing your HIV infection.** If you do not know whom to see, consult your local AIDS Resource Center or AIDS Network office for a recommendation or call the Wisconsin HIV/STD/Hepatitis C Information and Referral Center (IRC) hotline to obtain a referral. **In Wisconsin, call 1-800-334-2437 or e-mail [irc-wisconsin@arcw.org](mailto:irc-wisconsin@arcw.org).**

**Your health care provider can perform periodic examinations and arrange for appropriate tests to help you decide what treatments and interventions you may want to use.** Many people with HIV infection are being successfully treated with anti-viral drugs such as zidovudine (AZT) to slow the progress of the infection. Depending on the results of certain tests of your immune system, you may also benefit from therapies to prevent some infections. People with HIV infection also need regular tuberculosis (TB) screening and certain vaccinations. You and your health care provider can work out a schedule of follow-up visits appropriate for you.

**You may also want to utilize some self-care options and nonmedical therapies.** A nutritious diet, regular exercise, restful sleep, stress reduction, and spiritual peace (which are important for everyone) are even more helpful for many people with HIV infection. Some people with HIV infection find strength in meditation, massage, and specialized diets. If you are HIV positive, it is healthier to avoid alcohol and recreational drugs because they may damage your immune system.

**A positive test result may mean that you have to make changes in certain areas of your life.** It is much easier to make these adjustments with the help and support of others. There are support groups and counselors at most AIDS service organizations. You might seek support from your partner or trusted friends, family, clergy, or health professionals.

**Counseling can help you put things in perspective.** Some people who test positive find that counseling assists them in handling social and intimate relationships, dealing with fear, and promoting self-esteem. Professional counseling can help lessen the effects of the numerous issues that you may face.

**You have a responsibility to yourself and to others to avoid transmitting the virus.** Counselors can help you sort out your feelings about intimate relationships and help you learn about HIV risk-reduction methods. Not only should you avoid infecting others, but you should also avoid getting reinfected. Getting reinfected may help speed up the process of the HIV infection you already have.

**Being HIV positive means taking the right steps to maintain your health.** Dealing with the fear is healthier than avoiding the knowledge of HIV infection.

**For more information on HIV antibody testing and HIV related services, contact the IRC at 1-800-334-2437 or e-mail [irc-wisconsin@arcw.org](mailto:irc-wisconsin@arcw.org).**

Based on information contained in the brochure *The HIV Antibody Test*, produced by the American College Health Association.



**UNITED HOME LIFE INSURANCE COMPANY**  
**P.O. Box 7192**  
**Indianapolis, IN 46207-7192**  
**Phone: (317) 692-7979 Fax: (317) 692-7711**

**IMPORTANT NOTICE:  
 REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions.

**Do you have any existing insurance policies or annuities? \_\_\_\_YES \_\_\_\_NO**

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? \_\_\_\_YES \_\_\_\_NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? \_\_\_\_YES \_\_\_\_NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (including the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	Insurer Name	Contract Or Policy #	Insured Or Annuitant	Replaced (R) Or Financing (F)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_

I certify that the responses herein are, to the best of my knowledge, accurate:

\_\_\_\_\_  
 Applicant's Signature and Printed Name

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Producer's Signature and Printed Name

\_\_\_\_\_  
 Date

I do not want this notice read aloud to me. \_\_ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:** Are they affordable?  
Could they change?  
You're older – are premiums higher for the proposed new policy?  
How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:** New policies usually take longer to build cash values and to pay dividends.  
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.  
What surrender charges do the policies have?  
What expense and sales charges will you pay on the new policy?  
Does the new policy provide more insurance coverage?

**INSURABILITY:** If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.  
You may need a medical exam for a new policy.  
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.  
Suicide limitations may begin anew on the new coverage.

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

How are premiums for both policies being paid?  
How will the premiums on your existing policy be affected?  
Will a loan be deducted from death benefits?  
What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

Will you pay surrender charges on your old contract?  
What are the interest rate guarantees for the new contract?  
Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

What are the tax consequences of buying the new policy?  
Is this a tax free exchange? (See your tax advisor.)  
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?  
Will the existing insurer be willing to modify the old policy?  
How does the quality and financial stability of the new company compare with your existing company?



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**Do you have any existing insurance policies or annuities? \_\_\_\_YES \_\_\_\_NO**

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? \_\_\_\_YES \_\_\_\_NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? \_\_\_\_YES \_\_\_\_NO

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