



# NEW BUSINESS MEMO

## GUARANTEED ISSUE

### 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 Agt Name: _____ Agt # _____ Agt Phone: _____ Agt Fax: _____ Agt Email Address: _____@_____._____	
How do you prefer to be notified if we should need any additional information? <input type="checkbox"/> E-Mail <input type="checkbox"/> Fax <input type="checkbox"/> US Mail Street _____ City _____ State _____ Zip Code _____	
<p><b>This application must be completed with the proposed insured present.</b></p> Did you personally view a photo ID (driver's license, passport) of the proposed owner and/or insured? <input type="checkbox"/> Yes <input type="checkbox"/> No 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. _____	
Special Instructions you want us to know: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
<p><b>Application Completion "Tips"</b></p> <ol style="list-style-type: none"> <li>1. Make sure to use the app with the correct state variations</li> <li>2. If the first premium is going to be drafted from the client's bank account, <i>provide a copy of a pre-printed voided check!</i> Otherwise, the case will be unnecessarily delayed</li> <li>3. Print legibly in English</li> <li>4. Keep original app until policy is issued</li> <li>5. Keep fax confirmation message that fax was successful</li> </ol>	

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

# Graded Death Benefit Endowment 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	
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.a. Primary Beneficiary Name			Relationship		Age		
2.b. Contingent Beneficiary Name			Relationship		Age		
3.a. Owner Name			Relationship		Social Security Number		
Owner Street Address			City	State	Zip Code		
3.b. Contingent Owner Name			Relationship		Social Security Number		
4. Billing Street Address			City	State	Zip Code		
Secondary Addressee (For Past Due Notice)	Name	Street		City	State	Zip Code	
5.a. Plan of Insurance: Graded Death Benefit Endowment					5.b. Face Amount: \$ _____		
5.c. Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Qtrly. <input type="checkbox"/> PAC* Modal Premium Amount \$ _____ <b>*If selected, bank information on Page 3 must be fully completed.</b>							
6. Will this insurance replace or change any other insurance policies or annuities?						<input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes," please complete any necessary replacement forms.	
7. Has the Proposed Insured used nicotine in any form in the past twelve (12) months?						<input type="checkbox"/> Yes <input type="checkbox"/> 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 and the premium paid.

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

**AUTHORIZATION**

I authorize any health care professional, pharmacy benefit manager, medical facility, pharmacy, laboratory, insurance company, consumer reporting agency, the MIB, Inc., or other entity or person that has information about me, to furnish my entire medical record, prescription history, and other information about me (including information on the diagnosis or treatment of AIDS, HIV and sexually transmitted diseases, mental illness and use of alcohol, drugs or tobacco) to United Home Life Insurance Company ("UHL") or its reinsurers. I understand such information may be used by UHL to assess risks or obtain reinsurance. 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 acknowledge that such disclosed information may be subject to re-disclosure and no longer protected by federal or state privacy laws. I will receive a copy of this authorization upon request, and I have a right to revoke this authorization at any time by written request to UHL's Home Office. I understand that a revocation is not effective to the extent that UHL has relied on this authorization. This authorization will be valid for 24 months following the date the application is signed, and a copy or electronic image of this authorization is as valid as the original.

**\*\*\*WARNING\*\*\***

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

\$ \_\_\_\_\_ 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

**Agent's Report**

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.

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 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

**THE FOLLOWING INFORMATION IS EXTREMELY IMPORTANT**  
**Include copy of voided check for bank draft**

**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.**

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

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

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

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

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 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: \_\_\_\_\_

Bank signature of Premium Payor: \_\_\_\_\_ Date: \_\_\_\_\_

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**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 # (UHL): \_\_\_\_\_

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.