



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>This application must be completed with the proposed insured present.</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. _____ You must provide the proposed insured the attached Notice of Insurance Information Practices before submitting the application. | |
| Special Instructions you want us to know: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ | |
| <p>Application Completion "Tips"</p> <ol style="list-style-type: none"> 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, <i>provide a copy of a pre-printed voided check!</i> 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**



United Home 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.

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 \$ _____ *If selected, bank information on Page 3 must be fully completed. | | | | | | |
| 6. 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. | | | | | | |
| 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 (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) 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 or my authorized representative 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 applicant does does not have any existing life insurance policies or annuity contracts.

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: _____

**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. You may request to be interviewed in connection with the preparation of such report. Upon written request, a complete and accurate copy 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.

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.