

# CONNECTICUT – Application for Life Insurance

**Simplified issue Products** – One Base Policy per Application



Underwritten by  
United of Omaha Life Insurance Company  
A Mutual of Omaha Company

## Checklist for Submitting a Complete Application

Please mail application and appropriate forms to: United of Omaha Life Insurance Company,  
Attn: Individual Life Underwriting, Mutual of Omaha Plaza, Omaha, NE 68175

### Please choose the precise **Product, Plan, Rider, and amount of insurance** applied for

#### ☐ Universal Life Products:

- Indexed Universal Life Express

#### ☐ Universal Life Express Riders:

- Accidental Death Benefit Rider
- Guaranteed Insurability Rider
- Disability Waiver of Policy Charges Rider
- Disability Continuation of Planned Premium Rider
- Dependent Children's Rider

#### ☐ Term Product:

- Term Life Express

#### ☐ Term Life Riders:

- Accidental Death Benefit Rider
- Dependent Children's Rider
- Disability Income Rider
- Disability Waiver of Premium Rider

### Application Submission Guidelines

- ☐ Attach a cover letter or additional information as needed.
- ☐ Always submit the Producer Statement and Producer Report page.
- ☐ Always leave all applicable forms and the Life Insurance Buyer's Guide with the client.
- ☐ All changes should be initialed and dated by the Applicant/Owner.
- ☐ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

### Important Forms

- ☐ Replacement Notice – if applicable, the client must sign and retain a copy for their records.
- ☐ Payment Authorization – Complete this form if applicable.
- ☐ Conditional Receipt – Complete **ONLY** if you accepted a check or electronic transaction authorization at time of application for the initial premium. **DO NOT** complete the Conditional Receipt if initial payment won't be collected until issue.
- ☐ Accelerated Benefit Rider Disclosure – The client must sign the Accelerated Benefit Rider Disclosure Form.
- ☐ Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor – Complete this form if applicable. The client must sign and retain a copy for their records.

## Supplemental Applications, Forms, and Buyer's Guide:

- **Child(s) Rider Supplemental Application:** Required for the Children's Rider.
- **Disability Supplemental Application:** Required for the following riders - Disability Waiver of Policy Charges, Disability Continuation of Planned Premium, Disability Income or Disability Waiver of Premium.
- **Indexed Universal Life Premium Allocation form:** Required when selecting Indexed Universal Life Express Without Easy Solve on the application.
- **Illustration:** Required with signature for Indexed Universal Life Express applications.
- **Acknowledgment/Illustration Certification form:** Required when no illustration was used at point of sale, a hard copy of the illustration was not furnished or the policy applied for is other than shown in the illustration.
- **1035 Exchange:** By exercising a 1035 (a) exchange, the client may transfer the money from the old carrier to United of Omaha without incurring a taxable gain for federal income tax purposes.
- **Buyer's Guide:** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale.



LAP1111\_CT\_0713  
02/01/2022



Underwritten by  
United of Omaha Life Insurance Company  
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175



## INDIVIDUAL LIFE INSURANCE APPLICATION

| PROPOSED INSURED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                  |                                                                                                                                                                                 |               |                     |               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------|---------------|
| Name (First, Middle Initial, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | Social Security No.              | Sex                                                                                                                                                                             | Height        | Weight              | Annual Income |
| Home Address (Street, City, State, ZIP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                  | State of Birth                                                                                                                                                                  |               | Date of Birth       |               |
| Best Time to Call                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Phone Number                     |                                                                                                                                                                                 | E-mail        |                     |               |
| Driver's License No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | Driver's License State           | Occupation/Duties                                                                                                                                                               |               | Employer            |               |
| U.S. Citizen?.... <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," complete the Foreign National and Foreign Travel questionnaire)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                  | In the past 12 months, has the Proposed Insured used any form of tobacco, or any form of nicotine replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No |               |                     |               |
| PLAN INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                  |                                                                                                                                                                                 |               |                     |               |
| <b>TERM LIFE:</b><br><input type="checkbox"/> 30-Year Level Term Life with 30 Year Guarantee<br><input type="checkbox"/> 20-Year Level Term Life with 20 Year Guarantee<br><input type="checkbox"/> 15-Year Level Term Life with 15 Year Guarantee<br><input type="checkbox"/> 10-Year Level Term Life with 10 Year Guarantee                                                                                                                                                                                                                                                                                                                                             |  |                                  | Term Life Express Amount of Insurance Applied for<br>\$ _____                                                                                                                   |               |                     |               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                  | Return of Premium..... <input type="checkbox"/> Yes<br>(only available for 30-Year Guarantee)                                                                                   |               |                     |               |
| <b>TERM RIDERS: (COMPLETE SUPPLEMENTAL APPLICATIONS IF APPLYING FOR A DISABILITY RIDER OR THE CHILDREN'S RIDER)</b><br><input type="checkbox"/> Disability Income Rider (not available with Return of Premium): <input type="checkbox"/> 18 months <input type="checkbox"/> 30 months<br>Disability Income Rider Monthly Benefit \$ _____<br><input type="checkbox"/> Disability Waiver of Premium<br><input type="checkbox"/> Dependent Children's Rider Benefit Amount of Insurance Applied for: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000<br><input type="checkbox"/> Accidental Death Benefit Rider Amount of Insurance Applied for \$ _____ |  |                                  |                                                                                                                                                                                 |               |                     |               |
| <b>PERMANENT LIFE:</b><br><input type="checkbox"/> Indexed Universal Life Express Amount of Insurance Applied for \$ _____<br>Choose one: <input type="checkbox"/> <b>With Easy Solve</b><br>Level Death Benefit and 100% Allocated to the '1-Year 100% Participation Strategy'<br><i>Do NOT submit the IUL Allocation Form.</i><br><input type="checkbox"/> <b>Without Easy Solve</b><br><input type="checkbox"/> Option 1 Level Death Benefit<br><input type="checkbox"/> Option 2 Specified Amount Plus Accumulation Value<br><i>The IUL Allocation Form MUST be submitted.</i>                                                                                        |  |                                  |                                                                                                                                                                                 |               |                     |               |
| <b>PERMANENT LIFE RIDERS: (COMPLETE SUPPLEMENTAL APPLICATIONS IF APPLYING FOR A DISABILITY RIDER OR THE CHILDREN'S RIDER)</b><br><input type="checkbox"/> Disability Waiver of Policy Charges Rider <input type="checkbox"/> Disability Continuation of Planned Premium Rider Amount \$ _____<br><input type="checkbox"/> Dependent Children's Rider Benefit Amount of Insurance Applied for: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000<br><input type="checkbox"/> Accidental Death Benefit Rider Amount of Insurance Applied for \$ _____                                                                                                      |  |                                  |                                                                                                                                                                                 |               |                     |               |
| <b>PAYMENT MODE</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Other _____<br>Modal Premium \$ _____ Collected Premium \$ _____                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                  |                                                                                                                                                                                 |               |                     |               |
| <b>OWNER</b> (Complete Policyowner Information if Proposed Insured is not the Policyowner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                  |                                                                                                                                                                                 |               |                     |               |
| Name of Policyowner (First, Middle Initial, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Relationship to Proposed Insured |                                                                                                                                                                                 | Date of Birth | Phone No.           |               |
| Policyowner Address (Street, City, State, ZIP)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                  | Social Security No./Tax ID                                                                                                                                                      |               | Citizenship Country |               |

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| BENEFICIARY |  |
|-------------|--|
| NAME        |  |
| ADDRESS     |  |
| CITY        |  |
| STATE       |  |
| ZIP         |  |
| TELEPHONE   |  |
| DATE        |  |

|                        |               |                         |               |
|------------------------|---------------|-------------------------|---------------|
| Primary Beneficiary    | % of Proceeds | Relationship to Insured | Date of Birth |
| Contingent Beneficiary | % of Proceeds | Relationship to Insured | Date of Birth |

If more space is needed, provide information in Comments section.

## OTHER COVERAGE INFORMATION

1. List below all life insurance policies and/or annuity contracts on any person proposed for insurance that are now pending or are now in force (including any that have been assigned or sold). If none, check the following box.. ☐ **None**
2. Has the Proposed Insured had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? ..... ☐ **Yes** ☐ **No**
- The Producer shall comply with any additional state and/or company replacement requirements.**

| Company | Face Amount | ADB Amount | To Be Replaced or Converted?                             |
|---------|-------------|------------|----------------------------------------------------------|
|         |             |            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|         |             |            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|         |             |            | <input type="checkbox"/> Yes <input type="checkbox"/> No |

3. In the past 10 years, has the Proposed Insured been declined for life insurance coverage? ..... ☐ Yes ☐ No
4. Has the Proposed Insured been offered cash or any other consideration for obtaining this policy? ..... ☐ Yes ☐ No
5. Are you planning to enter into a finance arrangement to pay any premium payments due under this policy?..... ☐ Yes ☐ No
6. Do you intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? ..... ☐ Yes ☐ No
- If “Yes” to questions 3, 4, 5 or 6 provide information in Comments section.**

## COMMENTS

Provide any additional information necessary and the details of “Yes” answers. Always identify question number.

[illegible]

## UNDERWRITING

If the Proposed Insured answers "Yes" to questions 1 through 7 in this section, that person is not eligible for coverage under this application.

Proposed Insured

|                                                                                                                                                                                                                                                                                                                                                                                         |                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. Has the Proposed Insured ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC or HIV by a physician or health care provider? .....                                                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Has the Proposed Insured <b>ever</b> (i) been diagnosed with, or (ii) received care or treatment for, or (iii) been advised by a member of the medical profession to seek treatment for, or (iv) consulted with a health care provider regarding:                                                                                                                                    |                                                          |
| (a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease with Repair or Replacement, Cardiomyopathy, Congestive Heart Failure, Congenital Heart Disease, Stroke, Transient Ischemic Attack (TIA)/mini-stroke, abnormal heart rhythm, or Cerebral, Aortic or Thoracic Aneurysm? .....                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) Chronic Lung Disease (except mild Asthma), including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis? .....                                                                                                                                                                                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Sickle Cell Anemia, Lou Gehrig's Disease (ALS), Muscular Dystrophy, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down's Syndrome, Autism, mental incapacity, or any other disease of the central nervous system? ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C? .....                                                                                                                                                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (e) Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell or squamous cell skin cancer)? .....                                                                                                                                                                                                                                                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (f) Systemic Lupus or Scleroderma? .....                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (g) an organ transplant? .....                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Has the Proposed Insured <b>currently or within the past 12 months:</b>                                                                                                                                                                                                                                                                                                              |                                                          |
| (a) required the assistance of another person or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems? ..                                                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services or is the Proposed Insured currently confined to any hospital or other medical facility? .....                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? .....                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. In the past 12 months, has the Proposed Insured:                                                                                                                                                                                                                                                                                                                                     |                                                          |
| (a) been advised by a member of the medical profession to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, or other procedure which has not been done? .....                                                                                                                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds (other than due to diet or exercise), fatigue or unexplained gastrointestinal bleeding? .....                                                                                                                                                                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. In the next 2 years, will the Proposed Insured engage in any motor sports racing, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing? .....                                                                                                                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. In the past 10 years, has the Proposed Insured:                                                                                                                                                                                                                                                                                                                                      |                                                          |
| (a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a member of the medical profession? .....                                                                                                                                                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) used or been convicted of possession of unlawful drugs or used prescription drugs other than as prescribed in any form? .....                                                                                                                                                                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (c) been convicted of or currently awaiting trial for a felony? .....                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (d) been hospitalized for high blood pressure or any mental or nervous disorder? .....                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. In the past 5 years, has the Proposed Insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had four or more moving violations? .....                                                                                                                                                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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## UNDERWRITING CONTINUED

|                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <b>8.</b> Has the Proposed Insured ever (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:<br><b>(a)</b> Diabetes? .....<br><b>(b)</b> Diabetes before age 50 other than Gestational Diabetes?.....<br><b>(c)</b> Diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)? ..... | Proposed Insured                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>9.</b> In the past 12 months, has the Proposed Insured applied for or received disability, hospital or medical benefits from any insurance company, government, employer, or other source (other than for maternity, fractures, spinal or back disorders or hip or knee replacement)? .....                                                                                                                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>10.</b> In the past 5 years, has the Proposed Insured consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition (other than for routine physical checkups, eye, employment or FAA examinations)? .....                                                                                                                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If answered "Yes" to questions 8-10, please list details below. If more space is needed, use the Comments section in Part 1.

| Person Proposed for Insurance | Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type) | Month and Year | Duration | Degree of Recovery | Name, Address, ZIP and Telephone Number of Hospital and/or Attending Physician |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------|----------|--------------------|--------------------------------------------------------------------------------|
|                               |                                                                                                                    |                |          |                    |                                                                                |
|                               |                                                                                                                    |                |          |                    |                                                                                |
|                               |                                                                                                                    |                |          |                    |                                                                                |
|                               |                                                                                                                    |                |          |                    |                                                                                |

**11.** If the Proposed Insured is age 61 or older with a face amount greater than \$250,000, provide the name and address of personal physician.

## AUTHORIZATION AND AGREEMENT

**Authorization:** I authorize any medical provider, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical care facility, MIB, Inc. (MIB), state department of motor vehicles and other entities processing motor vehicle records, insurance companies or consumer reporting agencies to release information about me or my health, such as, medical history, including the presence of HIV infection, AIDS or ARC, mental or physical condition, prescription drug records, drug or alcohol use, driving record or insurance claims information, to United of Omaha Life Insurance Company ("United of Omaha"). The information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise. I also authorize United of Omaha to disclose information to MIB. I understand that my information received by MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations. This authorization is valid for 24 months from the date signed. I may refuse to sign this authorization but if I refuse, the insurance I am applying for will not be issued. I may revoke this authorization at any time by written notice to the address below. This revocation is limited to the extent that United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha to contest the issuance of the policy or a claim under the policy. I will receive a copy of this authorization.

**Agreement:** I represent the information above is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy effective the issue date. Unless otherwise provided under a conditional receipt, I understand that no insurance shall take effect until all outstanding application requirements have been received, a policy is issued and the first premium is received by United of Omaha during the proposed insured's lifetime. The issue date of the policy will be the date shown on the policy, even though coverage may not become effective until a later date. You must immediately notify United of Omaha if there has been a change in the proposed insured's health or habits that will change any statement or answer to any question in the application as of the date the policy is delivered. No policy of any kind will be in effect if the proposed insured dies or is otherwise ineligible for the insurance for which they applied. No producer can waive or change any receipt or policy provision or agree to issue any policy.

**Fraud Warning:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, EVEN IF UNINTENTIONAL, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE IF THE MISREPRESENTATION IS DEEMED TO BE MATERIAL.

Signed at: \_\_\_\_\_ Date \_\_\_\_\_  
 City State Mo Day Yr

Signature of Proposed Insured Age 15 and Over

Signature of Applicant/Owner/Trustee if other than Proposed Insured or if the Owner is a corporation, trust, or other entity. Include title of Signee(s).

Signature of Parent or Guardian if Proposed is under Age 15



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## PRODUCER STATEMENT

1. Has any person proposed for insurance informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? ..... ☐ Yes ☐ No  
If "Yes," give name(s) of the person(s) \_\_\_\_\_

2. Do you, the Producer(s), know or have reason to believe that the policy(ies) applied for has replaced or will replace any existing life insurance policies or annuity contracts? ..... ☐ Yes ☐ No

3. Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer's Guide and comply with all state and Company replacement requirements? ☐ Yes ☐ No If "No," please explain \_\_\_\_\_

4. I/We certify that, during an interview with the Proposed Insured, I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ☐ Yes ☐ No  
If "No," please explain \_\_\_\_\_

5. I conducted said interview in person ☐ Yes ☐ No If "No," please explain \_\_\_\_\_

6. (a) Are you related to the Proposed Insured or Owner? ☐ Yes ☐ No If "Yes," state relationship \_\_\_\_\_

(b) How long have you known the Proposed Insured? \_\_\_\_\_

(c) How long have you known the Proposed Owner? \_\_\_\_\_

7. Previous residence(s) of Proposed Insured for past five years.

| Address | From | To |
|---------|------|----|
|         |      |    |
|         |      |    |
|         |      |    |

Signature of Producer #1 \_\_\_\_\_ Production Number \_\_\_\_\_ Mo Day Yr

Signature of Producer #2 \_\_\_\_\_ Production Number \_\_\_\_\_ Mo Day Yr

Print or Stamp Producer #1 Name \_\_\_\_\_

Print or Stamp Producer #2 Name \_\_\_\_\_

General Agent/General Manager Name \_\_\_\_\_ General Agent/General Manager Stamp \_\_\_\_\_



# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

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## Producer's Report

(Must be completed by the Producer who obtained the application on the Proposed Primary Insured named below.)

1. Proposed Primary  
Insured Full Name \_\_\_\_\_  
First Name Initial Last Name

2. Please Note: A recent mortgage is not required for issuance of this policy.  
Has the Proposed Insured purchased a home or refinanced a home within the last 2 years? ..... ☐ Yes ☐ No  
**If "Yes," then complete the remainder of Question 2**

Approximate Mortgage Loan Amount \$ \_\_\_\_\_

Mortgage Loan Financial Institution Name \_\_\_\_\_

3. Have you, the producer, observed or are you aware of any additional information that may affect the issuance of this policy?  
If "Yes," explain below ..... ☐ Yes ☐ No

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# UNITED OF OMAHA LIFE INSURANCE COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600



## PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: \_\_\_\_\_ Policy Number(s) if known: \_\_\_\_\_

**Complete this form only when authorizing a bank account for withdrawal for a premium payment.**

### PAYMENT INFORMATION FOR THE FIRST PAYMENT- CAN BE DIFFERENT THAN THE ONGOING PAYMENTS

**Initial Premium Payment (select only one option)** Amount Quoted \$ \_\_\_\_\_

- ☐ Deduct premium immediately upon approval/issue
- ☐ Deduct initial premium on or after: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (Please Note: If the policy issue is after the date selected, the initial payment will be deducted on the date the policy is issued or all delivery requirements are received.)
- ☐ Check collected and mailed to Mutual of Omaha

Money will be deducted from your account as stated above. The first deduction may occur on a date different than the ongoing payments. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first deduction may exceed one regular payment amount. We **CANNOT** establish electronic payments from foreign banks.

### PAYMENT INFORMATION FOR ONGOING PAYMENTS- AUTOMATIC BANK ACCOUNT DEDUCTION

**Ongoing Automatic Monthly Premium Payments (Once a Month)- Select only one option**

- ☐ Choose the day payments will be deducted every month from your bank account:  
(1st through the 28th or Last Day of every month) \_\_\_\_\_
- OR-
- ☐ Choose the week and weekday that payments will be deducted every month from your bank account:  
(For example, 3rd Wednesday of every month)

**Week (1st, 2nd, 3rd, 4th, Last)** \_\_\_\_\_ **Weekday (Mon, Tue, Wed, Thu, Fri)** \_\_\_\_\_

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date lands on a weekend or holiday, the payment will process on the following business day.**

### PAYOR INFORMATION

Name of payor as shown on bank account: \_\_\_\_\_

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation may be required)

- ☐ Employer ☐ Living Trust
- ☐ Business owned by Proposed Insured/Insured or spouse ☐ Other \_\_\_\_\_
- ☐ Power of Attorney or legal guardian

### PAYOR ACCOUNT INFORMATION

1. Account Type (check one): ☐ Checking ☐ Savings

2. Name of Financial Institution: \_\_\_\_\_

3. Complete information below or attach a voided check here.

Bank Routing Number: \_\_\_\_\_ Bank Account Number: \_\_\_\_\_

(Do not use Debit/Credit Card numbers)

|                                     |                     |                                                                               |
|-------------------------------------|---------------------|-------------------------------------------------------------------------------|
| Memo _____                          | Signed By: _____    |                                                                               |
| 1:123456789:1 12345678 11* 1234 11* |                     |                                                                               |
| Bank Routing Number                 | Bank Account Number | Check Number (if shown at bottom, may be shown before or after the account #) |

### PAYOR AUTHORIZATION

I authorize United of Omaha Life Insurance Company to initiate any initial or recurring preauthorized electronic transfers from my account. I understand the amounts may vary as premium shortages may result from a variety of reasons, including underwriting adjustments. This authorization will be effective until I give you at least three business days notice to cancel. If notice is given verbally, United of Omaha Life Insurance Company may require written confirmation within 15 days after my verbal notice.

Date \_\_\_\_\_ X \_\_\_\_\_  
Mo./Day/Yr. Payor Authorized Signature as Shown on Account

# Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

|                                                                                                                                   |               |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------|
|  <b>X</b><br>_____<br>Signature of Applicant A | _____<br>Date |
|  <b>X</b><br>_____<br>Signature of Applicant B | _____<br>Date |



## ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

***The benefits received under any accelerated death benefit rider may be taxable and may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor regarding the tax treatment of accelerated benefits. You should contact the Social Security Administration for advice regarding eligibility for Medicaid or other government benefits or entitlements before requesting this benefit.***

***Accelerated benefits do not and are not intended to qualify as long-term care insurance. This rider is not a long term care policy as defined in sections 38a-501 and 38a-528 of the Connecticut General Statutes.***

### Disclosure for Term Life Insurance Policies

If you are applying for term life insurance, this disclosure is a brief description of the Accelerated Death Benefit Rider and the effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the riders. There is no premium charge for the riders.

### Return of Premium:

#### Benefit Description - Accelerated Death Benefit for Terminal Illness Rider

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 92% of the policy's death benefit. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 24 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness.

#### Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

#### Benefit Description - Accelerated Death Benefit for Chronic Illness Rider

While the rider is in force and the Insured is diagnosed as having a Chronic Illness, you may make a one-time election to receive an accelerated death benefit.

A Chronic Illness means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairments.

We will reduce the Chronic Illness benefit by an actuarial present value factor, future unpaid premiums, and a \$100 charge. The actuarial present value factor will be based on the life expectancy of the insured and the Accelerated Death Benefit Interest Rate.

#### Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

#### Benefit Description - Accelerated Death Benefit for Critical Illness Rider

While the rider is in force and the Insured is diagnosed as having a Critical Illness, you may make a one-time election to receive an accelerated death benefit.

Critically Ill means that within the last 12 months a physician has certified that the insured has one or more of the following conditions:

AIDS, Amyotrophic Lateral Sclerosis (ALS), Dementia, End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack), Severe Burns,

Stroke or Surgical Treatment of an Aortic Aneurysm.

We will reduce the Critical Illness benefit by an actuarial present value factor, future unpaid premiums, and a \$100 charge. The actuarial present value factor will be based on the life expectancy of the insured and the Accelerated Death Benefit Interest Rate.

#### Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

### Non-Return of Premium

#### Benefit Description - Accelerated Death Benefit for Terminal Illness Rider

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit up to 80% of the policy's death benefit. A Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

We will reduce the Terminal Illness benefit by the Accelerated Death Benefit Interest Rate and a \$100 charge.

#### Benefit Description - Accelerated Death Benefit for Chronic Illness Rider

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairments.

Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

We will reduce the Chronic Illness benefit by an actuarial present value factor, future unpaid premiums, and a \$100 charge. The actuarial present value factor will be based on the life expectancy of the insured and the Accelerated Death Benefit Interest Rate.



- continued on next page -

## Requesting an Acceleration

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

The requested acceleration cannot be less than \$5,000 under any rider. The maximum sum of all accelerated death benefit payments, for the policy to which this rider is attached, cannot exceed 80% of the policy's face amount as of the policy issue date. The issue date and face amount are shown on the policy data page.

## Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy will continue with a reduced face amount and a reduced premium.

## Disclosure for Universal Life Insurance Policies

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider, the Accelerated Death Benefit for Chronic Illness Rider, and their effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the riders. There is no premium or cost of insurance for these riders.

### Benefit Description - Accelerated Death Benefit For Terminal Illness Rider

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit. The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of \$1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by 6% of the requested acceleration, a \$100 charge, and the pro-rated amount of any outstanding loans.

### Benefit Description - Accelerated Death Benefit for Chronic Illness Rider

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or requires substantial supervision to protect himself or herself from threats and safety due to severe cognitive impairments; and (b) has been confined to his or her place of residence or an

institution for six consecutive months or more; and is expected to remain confined to his or her place of residence or institution for the duration of the Insured's life.

The sum of all requested accelerations may not exceed the lesser of \$1,000,000 or 80% of the specified amount as of the date of the first requested acceleration. Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by a charge equal to 6% of the requested acceleration multiplied by the insured's life expectancy in years, a \$100 charge, and the pro-rated amount of any outstanding loans.

### Benefit Description - Accelerated Death Benefit for Critical Illness Rider (this rider is only available with indexed universal life express policies)

If the insured is diagnosed as being Critically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Critically Ill means that within the last 12 months a physician has certified that the insured has one or more of the following conditions: AIDS, Amyotrophic Lateral Sclerosis (ALS), Dementia, End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack), Severe Burns, Stroke or Surgical Treatment of an Aortic Aneurysm.

The minimum acceleration amount under this rider is \$5,000. The maximum sum of all accelerated death benefit payments cannot exceed 80% of the policy's face amount as of the policy issue date. You may elect to receive the Critical Illness benefit more than once, and there must be at least 12 months between acceleration requests.

We will reduce the Critical Illness benefit by an actuarial present value factor, future unpaid premiums, and a \$100 charge. The actuarial present value factor will be based on the life expectancy of the insured and the Accelerated Death Benefit Interest Rate.

### Effect of the Accelerated Death Benefit on the Policy

When we pay any accelerated death benefit, the following will occur: (a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the death benefit; and (b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.



## Acknowledgment

I acknowledge receipt of this Disclosure Form



Applicant/Owner Signature

Date

I have provided this Disclosure Form to the Applicant



Producer Signature

Date

# CONDITIONAL RECEIPT ("RECEIPT")

United of Omaha Life Insurance Company ("United", "we"), Mutual of Omaha Plaza, Omaha, NE 68175

**IF ANY PROPOSED INSURED DIES WHILE COVERAGE UNDER THIS RECEIPT IS IN EFFECT, WE WILL PAY TO THE BENEFICIARY(IES) NAMED IN THE APPLICATION THE AMOUNT DESCRIBED IN THE SECTION BELOW ENTITLED "BENEFIT".**

**DATE OF RECEIPT:** \_\_\_\_\_

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>BENEFIT</b> | For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) \$100,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed \$100,000. |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CONDITIONS</b> | <p>Conditions under which a benefit may be payable under this Receipt prior to policy delivery:</p> <ol style="list-style-type: none"><li>1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and</li><li>2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and</li><li>3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and</li><li>4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.</li></ol> <p>If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.</p> |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>END DATE</b> | <p>This Receipt and any coverage provided hereunder will <b>END</b> on the earliest of the following dates:</p> <ol style="list-style-type: none"><li>1 60 days from the date of this Receipt; or</li><li>2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or</li><li>3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or</li><li>4 The date the Applicant/Owner withdraws the application for insurance.</li></ol> |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               |       |      |       |                                     |       |      |       |                                                               |       |      |       |                       |       |      |       |                       |       |      |       |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------|------|-------|-------------------------------------|-------|------|-------|---------------------------------------------------------------|-------|------|-------|-----------------------|-------|------|-------|-----------------------|-------|------|-------|
| <b>SIGNATURES</b>                                             | <p>This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.</p> <p>I/We have read and received a copy of this Receipt and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.</p> <table><tr><td>Signature of Proposed Insured</td><td>_____</td><td>Date</td><td>_____</td></tr><tr><td>Signature of Other Proposed Insured</td><td>_____</td><td>Date</td><td>_____</td></tr><tr><td>Signature of Applicant/Owner (if other than Proposed Insured)</td><td>_____</td><td>Date</td><td>_____</td></tr></table> <p>Payment Method: Check <input type="checkbox"/>    Electronic Transaction Authorization <input type="checkbox"/>    Amount remitted/authorized \$ _____</p> <p>I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.</p> <table><tr><td>Signature of Producer</td><td>_____</td><td>Date</td><td>_____</td></tr><tr><td>Signature of Producer</td><td>_____</td><td>Date</td><td>_____</td></tr></table> | Signature of Proposed Insured | _____ | Date | _____ | Signature of Other Proposed Insured | _____ | Date | _____ | Signature of Applicant/Owner (if other than Proposed Insured) | _____ | Date | _____ | Signature of Producer | _____ | Date | _____ | Signature of Producer | _____ | Date | _____ |
| Signature of Proposed Insured                                 | _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Date                          | _____ |      |       |                                     |       |      |       |                                                               |       |      |       |                       |       |      |       |                       |       |      |       |
| Signature of Other Proposed Insured                           | _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Date                          | _____ |      |       |                                     |       |      |       |                                                               |       |      |       |                       |       |      |       |                       |       |      |       |
| Signature of Applicant/Owner (if other than Proposed Insured) | _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Date                          | _____ |      |       |                                     |       |      |       |                                                               |       |      |       |                       |       |      |       |                       |       |      |       |
| Signature of Producer                                         | _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Date                          | _____ |      |       |                                     |       |      |       |                                                               |       |      |       |                       |       |      |       |                       |       |      |       |
| Signature of Producer                                         | _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Date                          | _____ |      |       |                                     |       |      |       |                                                               |       |      |       |                       |       |      |       |                       |       |      |       |





Underwritten by  
United of Omaha Life Insurance Company  
A Mutual of Omaha Company

## Third Party Notice Request Form

You have the right to designate a person, in addition to yourself, to receive notice that your premium is past due and has not been paid.

You can designate this additional person to receive notice of nonpayment now or at a later time, provided the policy is in force, and you give us written notice containing the additional person's name and address.

You have the right to change this third-party designation at any time; however, you must submit the change in writing to the address below.

I wish to designate an additional person to receive notice of nonpayment of premium.

Policyowner/Certificateholder: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Date: \_\_\_\_\_

Third Party: \_\_\_\_\_  
(Please print name of other person to receive notice of nonpayment)

Third Party Address: \_\_\_\_\_  
(Street Address) (City) (State) (ZIP)

Signature of Policyowner/Certificateholder

\_\_\_\_\_

Date \_\_\_\_\_

Direct all correspondence to: United of Omaha Life Insurance Company  
3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175



L8602

## IMPORTANT DOCUMENTS

### LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s). **However, do not provide the Conditional Receipt to the client if a check or electronic transaction authorization for the initial premium was not collected at the time of application.**



## ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

***The benefits received under any accelerated death benefit rider may be taxable and may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor regarding the tax treatment of accelerated benefits. You should contact the Social Security Administration for advice regarding eligibility for Medicaid or other government benefits or entitlements before requesting this benefit.***

***Accelerated benefits do not and are not intended to qualify as long-term care insurance. This rider is not a long term care policy as defined in sections 38a-501 and 38a-528 of the Connecticut General Statutes.***

### Disclosure for Term Life Insurance Policies

If you are applying for term life insurance, this disclosure is a brief description of the Accelerated Death Benefit Rider and the effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the riders. There is no premium charge for the riders.

### Return of Premium:

#### Benefit Description - Accelerated Death Benefit for Terminal Illness Rider

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 92% of the policy's death benefit. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 24 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness.

#### Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

#### Benefit Description - Accelerated Death Benefit for Chronic Illness Rider

While the rider is in force and the Insured is diagnosed as having a Chronic Illness, you may make a one-time election to receive an accelerated death benefit.

A Chronic Illness means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairments.

We will reduce the Chronic Illness benefit by an actuarial present value factor, future unpaid premiums, and a \$100 charge. The actuarial present value factor will be based on the life expectancy of the insured and the Accelerated Death Benefit Interest Rate.

#### Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

#### Benefit Description - Accelerated Death Benefit for Critical Illness Rider

While the rider is in force and the Insured is diagnosed as having a Critical Illness, you may make a one-time election to receive an accelerated death benefit.

Critically Ill means that within the last 12 months a physician has certified that the insured has one or more of the following conditions:

AIDS, Amyotrophic Lateral Sclerosis (ALS), Dementia, End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack), Severe Burns,

Stroke or Surgical Treatment of an Aortic Aneurysm.

We will reduce the Critical Illness benefit by an actuarial present value factor, future unpaid premiums, and a \$100 charge. The actuarial present value factor will be based on the life expectancy of the insured and the Accelerated Death Benefit Interest Rate.

#### Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

### Non-Return of Premium

#### Benefit Description - Accelerated Death Benefit for Terminal Illness Rider

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit up to 80% of the policy's death benefit. A Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

We will reduce the Terminal Illness benefit by the Accelerated Death Benefit Interest Rate and a \$100 charge.

#### Benefit Description - Accelerated Death Benefit for Chronic Illness Rider

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairments.

Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

We will reduce the Chronic Illness benefit by an actuarial present value factor, future unpaid premiums, and a \$100 charge. The actuarial present value factor will be based on the life expectancy of the insured and the Accelerated Death Benefit Interest Rate.



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## Requesting an Acceleration

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

The requested acceleration cannot be less than \$5,000 under any rider. The maximum sum of all accelerated death benefit payments, for the policy to which this rider is attached, cannot exceed 80% of the policy's face amount as of the policy issue date. The issue date and face amount are shown on the policy data page.

## Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy will continue with a reduced face amount and a reduced premium.

## Disclosure for Universal Life Insurance Policies

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider, the Accelerated Death Benefit for Chronic Illness Rider, and their effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the riders. There is no premium or cost of insurance for these riders.

### Benefit Description - Accelerated Death Benefit For Terminal Illness Rider

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit. The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of \$1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by 6% of the requested acceleration, a \$100 charge, and the pro-rated amount of any outstanding loans.

### Benefit Description - Accelerated Death Benefit for Chronic Illness Rider

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or requires substantial supervision to protect himself or herself from threats and safety due to severe cognitive impairments; and (b) has been confined to his or her place of residence or an

institution for six consecutive months or more; and is expected to remain confined to his or her place of residence or institution for the duration of the Insured's life.

The sum of all requested accelerations may not exceed the lesser of \$1,000,000 or 80% of the specified amount as of the date of the first requested acceleration. Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by a charge equal to 6% of the requested acceleration multiplied by the insured's life expectancy in years, a \$100 charge, and the pro-rated amount of any outstanding loans.

### Benefit Description - Accelerated Death Benefit for Critical Illness Rider (this rider is only available with indexed universal life express policies)

If the insured is diagnosed as being Critically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Critically Ill means that within the last 12 months a physician has certified that the insured has one or more of the following conditions: AIDS, Amyotrophic Lateral Sclerosis (ALS), Dementia, End Stage Renal Failure (Kidney Failure), Life Threatening (Invasive) Cancer, Major Organ Failure, Myocardial Infarction (Heart Attack), Severe Burns, Stroke or Surgical Treatment of an Aortic Aneurysm.

The minimum acceleration amount under this rider is \$5,000. The maximum sum of all accelerated death benefit payments cannot exceed 80% of the policy's face amount as of the policy issue date. You may elect to receive the Critical Illness benefit more than once, and there must be at least 12 months between acceleration requests.

We will reduce the Critical Illness benefit by an actuarial present value factor, future unpaid premiums, and a \$100 charge. The actuarial present value factor will be based on the life expectancy of the insured and the Accelerated Death Benefit Interest Rate.

### Effect of the Accelerated Death Benefit on the Policy

When we pay any accelerated death benefit, the following will occur: (a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the death benefit; and (b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.



## Acknowledgment

I acknowledge receipt of this Disclosure Form



Applicant/Owner Signature

Date

I have provided this Disclosure Form to the Applicant



Producer Signature

Date

# Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

|                                                                                                                                   |               |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------|
|  <b>X</b><br>_____<br>Signature of Applicant A | _____<br>Date |
|  <b>X</b><br>_____<br>Signature of Applicant B | _____<br>Date |



## CONDITIONAL RECEIPT ("RECEIPT")

United of Omaha Life Insurance Company ("United", "we"), Mutual of Omaha Plaza, Omaha, NE 68175

**IF ANY PROPOSED INSURED DIES WHILE COVERAGE UNDER THIS RECEIPT IS IN EFFECT, WE WILL PAY TO THE BENEFICIARY(IES) NAMED IN THE APPLICATION THE AMOUNT DESCRIBED IN THE SECTION BELOW ENTITLED "BENEFIT".**

**DATE OF RECEIPT:** \_\_\_\_\_

|                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>BENEFIT</b> | For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) \$100,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed \$100,000. |
|----------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CONDITIONS</b> | <p>Conditions under which a benefit may be payable under this Receipt prior to policy delivery:</p> <ol style="list-style-type: none"><li>1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and</li><li>2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and</li><li>3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and</li><li>4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.</li></ol> <p>If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.</p> |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>END DATE</b> | <p>This Receipt and any coverage provided hereunder will <b>END</b> on the earliest of the following dates:</p> <ol style="list-style-type: none"><li>1 60 days from the date of this Receipt; or</li><li>2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or</li><li>3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or</li><li>4 The date the Applicant/Owner withdraws the application for insurance.</li></ol> |
|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|------|-------------------------------------|------|---------------------------------------------------------------|------|-----------------------|------|-----------------------|------|
| <b>SIGNATURES</b>                                             | <p>This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.</p> <p>I/We have read and received a copy of this Receipt and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.</p> <table><tr><td>Signature of Proposed Insured</td><td>Date</td></tr><tr><td>Signature of Other Proposed Insured</td><td>Date</td></tr><tr><td>Signature of Applicant/Owner (if other than Proposed Insured)</td><td>Date</td></tr></table> <p>Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> Amount remitted/authorized \$ _____</p> <p>I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.</p> <table><tr><td>Signature of Producer</td><td>Date</td></tr><tr><td>Signature of Producer</td><td>Date</td></tr></table> | Signature of Proposed Insured | Date | Signature of Other Proposed Insured | Date | Signature of Applicant/Owner (if other than Proposed Insured) | Date | Signature of Producer | Date | Signature of Producer | Date |
| Signature of Proposed Insured                                 | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |      |                                     |      |                                                               |      |                       |      |                       |      |
| Signature of Other Proposed Insured                           | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |      |                                     |      |                                                               |      |                       |      |                       |      |
| Signature of Applicant/Owner (if other than Proposed Insured) | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |      |                                     |      |                                                               |      |                       |      |                       |      |
| Signature of Producer                                         | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |      |                                     |      |                                                               |      |                       |      |                       |      |
| Signature of Producer                                         | Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |      |                                     |      |                                                               |      |                       |      |                       |      |



## United of Omaha Life Insurance Company - MIB, LLC Pre-Notice

Information regarding your insurability will be treated as confidential. United of Omaha Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, LLC which operates an information exchange on behalf of insurance companies that are members of the MIB Group, Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. 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 is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

United of Omaha Life Insurance Company, or its reinsurers, may also release information in its file to other 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).

## United of Omaha Life Insurance - Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate. In the event of an adverse underwriting decision, our Company will provide in writing the specific reason for the underwriting decision.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.**  
L8303

**Applicant's/Owner's Copy**

L8580\_1022



# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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## Replacement of Life Insurance or Annuities

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:

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- 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:

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- 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:

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- 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:

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- 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:

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- 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:

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- 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?



**UNITED OF OMAHA LIFE INSURANCE COMPANY**

A MUTUAL of OMAHA COMPANY

**Important Notice:  
Replacement of Life Insurance or Annuities**

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 interest. 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 and consider the questions on this form.

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
3. If purchasing an annuity, have you had another annuity exchange or replacement within the past 60 months? ☐ YES ☐ NO

If you answered "yes" to any of the above questions, list each existing policy or contract you are contemplating replacing (include 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) |
|--------------|----------------------|----------------------|-------------------------------|
|              |                      |                      |                               |
|              |                      |                      |                               |
|              |                      |                      |                               |

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 \_\_\_\_\_

If you are replacing, list below the form number(s) and brief description(s) of preprinted or electronic sales material which was presented, or check "NONE" box if no sales material was used in this sale: ..... ☐ NONE  
(The producer must provide the applicant with a copy of all sales material used at time of application, including electronically presented sales material in printed form no later than the time of policy or contract delivery.)

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

| Applicant                                | Applicant B (if applicable)              |
|------------------------------------------|------------------------------------------|
| Printed Name of Proposed Applicant/Owner | Printed Name of Proposed Applicant/Owner |
| Signature of Proposed Applicant/Owner    | Signature of Proposed Applicant/Owner    |
| Date                                     | Date                                     |

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Producer's 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.)

Applicant/Owner Copy

L6232\_0513

**UNITED OF OMAHA LIFE INSURANCE COMPANY**

A MUTUAL of OMAHA COMPANY

**Important Notice:  
Replacement of Life Insurance or Annuities**

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You should carefully consider whether a replacement is in your best interest. 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 and consider the questions on this form.

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
3. If purchasing an annuity, have you had another annuity exchange or replacement within the past 60 months? ☐ YES ☐ NO

If you answered "yes" to any of the above questions, list each existing policy or contract you are contemplating replacing (include 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) |
|--------------|----------------------|----------------------|-------------------------------|
|              |                      |                      |                               |
|              |                      |                      |                               |
|              |                      |                      |                               |

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

If you are replacing, list below the form number(s) and brief description(s) of preprinted or electronic sales material which was presented, or check "NONE" box if no sales material was used in this sale: ..... ☐ NONE  
(The producer must provide the applicant with a copy of all sales material used at time of application, including electronically presented sales material in printed form no later than the time of policy or contract delivery.)

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

| Applicant                                | Applicant B (if applicable)              |
|------------------------------------------|------------------------------------------|
| Printed Name of Proposed Applicant/Owner | Printed Name of Proposed Applicant/Owner |
| Signature of Proposed Applicant/Owner    | Signature of Proposed Applicant/Owner    |
| Date                                     | Date                                     |

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Producer's 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.)

Company's Copy

L6232\_0513



Underwritten by  
United of Omaha Life Insurance Company  
A Mutual of Omaha Company

# LIFE APPLICATION SUBMISSION FORM

**Send to: Individual Life Underwriting**  
**United of Omaha Life Insurance Company**  
**3300 Mutual of Omaha Plaza**  
**Omaha, NE 68175**

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

|                        |
|------------------------|
| <b>Name of Insured</b> |
|                        |

| <b>Name of Agent</b> | <b>Production Number</b> | <b>Phone Number</b> | <b>Email Address</b> |
|----------------------|--------------------------|---------------------|----------------------|
|                      |                          |                     |                      |

| <b>Next Highest Upline</b> | <b>Production Number</b> | <b>Phone Number</b> | <b>Email Address</b> |
|----------------------------|--------------------------|---------------------|----------------------|
|                            |                          |                     |                      |

Please list any underwriting requirements that have already been ordered by the agent or Master General Agent/Broker General Agent.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_