VERMONT – Application for Life Insurance

FULLY UNDERWRITTEN PRODUCTS – One Base Policy Per Application

Checklist for Submitting a Complete Application

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

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

PRODUCTS	OPTIONAL RIDERS
❏ Term Life Answers (TLA)	❏ Disability Waiver of Premium Rider ❏ Other Insured Rider ❏ Dependent Children's Rider ($1,000 - $10,000) ❏ Accidental Death Benefits Rider
❏ AccumUL Answers ❏ Income Advantage (IUL) ❏ Life Protection Advantage (IUL)	❏ Disability Waiver of Policy Charges ❏ Disability Continuation of Planned Premium Rider ❏ Guaranteed Insurability Rider ($10,000-$50,000) ❏ Dependent Children's Rider ($1,000 - $10,000) ❏ Accidental Death Benefit Rider ❏ Additional Insured Term Rider - Self & Other Insured ❏ Long-Term Care Benefits Rider (Income Advantage & Life Protection Advantage Only)

APPLICATION SUBMISSION GUIDELINES

- ❏ Attach a cover letter or additional information as needed**, and** Always submit the Producer Statement and Producer Report page
- ❏ Always obtain signed HIPAA/MIB authorization
- ❏ Leave all applicable forms and Life Insurance Buyer's Guide with the Proposed Insured
- ❏ 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
- ❏ If selecting the Disability Continuation of Planned Premium Rider, Guaranteed Insurability Rider, Accidental Death Benefit Rider, Dependent Children's Rider, Additional Insured Term Rider or the Other Insured Rider, a **RIDER AMOUNT** must be entered on the application.

IMPORTANT FORMS

- ❏ Replacement Notice – If applicable, the client must sign and retain a copy for their records
- ❏ Payment Authorization – Complete this form if applicable
- ❏ Complete two copies of the TIA form and leave the unsigned copy with the applicant when: a) all 6 questions on the TIA are answered "no"; and b) a check or electronic transaction authorization for the initial premium is collected. **DO NOT** collect a check if any of the 6 TIA questions are answered "yes" - a completed electronic transaction authorization may still be submitted. **DO NOT** complete the TIA if initial payment won't be collected until issue.
- ❏ You will need a signed Accelerated Death Benefit Rider Disclosure Form
- ❏ If face amount is $100,000 or over, you will need a signed HIV consent form (If your state does not require the HIV Consent form, then this form will not be included in this application package)
- ❏ If face amount is $1,000,000 and above and the Proposed Insured is age 65, or over you will need: (a) signed Statement of Policyowner form and, (b) signed Premium Funding and Acknowledgement form
- ❏ Federal Form F4506T-EZ - Used to request tax records for the insured. This form is required for applications with a face amount of greater than $5 million and may be requested by underwriting as necessary.
- ❏ 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 & BUYER'S GUIDE

- ***Child(s) Rider Supplemental Application:*** Complete if applying for the Children's Rider
- ***Juvenile Life Insurance Supplemental Application:*** Complete if applying for life insurance for proposed insured ages 0-17 years
- ***Long-Term Care Benefits Rider Supplemental Application Packet:*** Complete if applying for the Long-Term Care Rider
- ***Indexed Universal Life Premium Allocation form:*** Complete if applying for Income Advantage or LIfe Protection Advantage
- ***Acknowledgment/Illustration Certification form:*** If applicable, required when no illustration was used at point of sale, or the policy applied for is other than as shown in the illustration, or a computer screen illustration was displayed at point of sale but no hard copy was furnished
- ***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

Paramedical Vendors	Indicate underwriting requirements initiated or completed on the Proposed Insured(s)	
APPS – 1-800-635-1677 **ExamOne** – 1-877-933-9261	**Primary Proposed Insured** ☐ Blood Profile ☐ Urinalysis ☐ Physical Data ☐ MD Exam ☐ Long Form Exam ☐ EKG ☐ Treadmill EKG	**Other Proposed Insured:** ☐ Blood Profile ☐ Urinalysis ☐ Physical Data ☐ MD Exam ☐ Long Form Exam ☐ EKG ☐ Treadmill EKG

Mutual of Omaha

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 PART 1, PAGE 1 OF 4

PROPOSED INSURED (If Proposed Insured is age 0-17, complete the Juvenile Supplemental Application)

Name (First, Middle Initial, Last)		Social Security Number	Gender at Birth ☐ Male ☐ Female
Home Address (Street, City, State, ZIP)			Marital Status
Primary Phone No.	Secondary Phone No.	E-mail	
Driver's License No. (If none, please explain)			Driver's License State
Occupation/Duties		Annual Income	Employer
Date of Birth	State of Birth (Country if not U.S.)	U.S. Citizen?....☐Yes ☐No **(If No, complete the Foreign National and Foreign Travel questionnaire)**	

Have you ever used any form of tobacco or any form of nicotine replacement therapy?..☐**Yes** ☐**No** Date Stopped________________ month/year
(If Yes, provide details in the Comments section.)

PROPOSED INSURED BENEFICIARY (If more space is needed, use the Comments section)

Primary Beneficiary	% of Proceeds	Date of Birth	Relationship to Proposed Insured
Contingent Beneficiary	% of Proceeds	Date of Birth	Relationship to Proposed Insured

OTHER PROPOSED INSURED (If Other Proposed Insured is age 0-17, complete the Juvenile Supplemental Application)

Name (First, Middle Initial, Last)		Social Security Number	Gender at Birth ☐ Male ☐ Female
Home Address (Street, City, State, ZIP)			Relationship to Proposed Insured
Primary Phone No.	Secondary Phone No.	E-mail	
Driver's License No. (If none, please explain)			Driver's License State
Occupation/Duties		Annual Income	Employer
Date of Birth	State of Birth (Country if not U.S.)	U.S. Citizen?....☐Yes ☐No **(If No, complete the Foreign National and Foreign Travel questionnaire)**	

Have you ever used any form of tobacco or any form of nicotine replacement therapy?..☐**Yes** ☐**No** Date Stopped________________ month/year
(If Yes, provide details in the Comments section.)

OTHER PROPOSED INSURED BENEFICIARY (If more space is needed, use the Comments section)

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

OWNER (Complete Policyowner Information if Proposed Insured is not the Policyowner)

Owner Is: ☐ Individual ☐ Employer ☐ Trust ☐ Other (Specify): ________________________

Name of Policyowner (First, Middle Initial, Last)	Relationship to Proposed Insured	Social Security No./Tax ID

Policyowner Address (Street, City, State, ZIP)	Date of Birth/Date of Trust

Policyowner Phone No.	Policyowner E-mail

Secondary Addressee - Optional. This person will receive copies of overdue premium and lapse notices.

Name____

Address____
Street City State ZIP

PLAN INFORMATION

RISK/RATE CLASS APPLIED FOR:

☐ Standard or Best Available Risk Class

☐ Substandard Risk Class Proposed: Table ______________________________

TERM LIFE PLAN AMOUNT OF INSURANCE APPLIED FOR: $___________________________

Product Selection	Optional Riders
☐ Term Life Answers (TLA) 10-Year Term Life ☐ Term Life Answers (TLA) 15-Year Term Life ☐ Term Life Answers (TLA) 20-Year Term Life ☐ Term Life Answers (TLA) 30-Year Term Life	☐ Disability Waiver of Premium ☐ Other Insured Rider: $_________________ ☐ Dependent Children's Rider: $__________________ ☐ Accidental Death Benefit Rider: $__________________

UNIVERSAL LIFE PLAN AMOUNT OF INSURANCE APPLIED FOR: $___________________________

Product Selection	Death Benefit (pick one)	Optional Riders
☐ Income Advantage (IUL) ☐ Life Protection Advantage (IUL) ☐ Other: ___________________________	☐ UL Option 1 Level Death Benefit ☐ UL Option 2 Specified Amount plus Accumulation Value	☐ Disability Waiver of Policy Charges ☐ Disability Continuation of Planned Premium Rider: $___________ ☐ Guaranteed Insurability Rider: $____________________ ☐ Dependent Children's Rider: $__________________ ☐ Accidental Death Benefit Rider: $__________________ ☐ Additional Insured Term Rider (Self): $___________________ ☐ Additional Insured Term Rider (Other Insured): $_____________ ☐ Long-Term Care Benefits Rider
☐ AccumUL Answers	☐ UL Option 1 Level Death Benefit ☐ UL Option 2 Specified Amount plus Accumulation Value	☐ Disability Waiver of Policy Charges ☐ Disability Continuation of Planned Premium Rider: $___________ ☐ Guaranteed Insurability Rider: $____________________ ☐ Dependent Children's Rider: $__________________ ☐ Accidental Death Benefit Rider: $__________________ ☐ Additional Insured Term Rider (Self): $___________________ ☐ Additional Insured Term Rider (Other Insured): $_____________

PREMIUM INFORMATION

Premium Method	☐ Direct Bill ☐ Bank Draft *(Monthly Only) (Complete Payment Authorization Form)* ☐ Other *(Please Explain)* ____
Frequency of Modal Premium	☐ Monthly *(Bank Draft Only)* ☐ Annual ☐ Semi-Annual ☐ Quarterly
Modal Premium $__________________ Collected Premium $_________________	Date Policy to Save Age? . . . . Proposed Insured: ☐**Yes** ☐ **No** Other Proposed Insured: ☐**Yes** ☐ **No**

ICC116L660A

FULLY 13

Insurance History

1. Have you been offered cash, or any other consideration for obtaining this policy? ☐ Yes ☐ No
2. Are you planning to enter into a finance arrangement to pay any premium payments due under this policy? ☐ Yes ☐ No
3. 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 1, 2 or 3, provide information in Comments section.)
4. In the past 12 months, have you applied for any life insurance or do you have any life insurance currently pending, excluding this application? ☐ Yes ☐ No
5. Do you have any existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No
6. Will this insurance replace or change any existing life insurance or annuity contract with the company or any other company? ☐ Yes ☐ No
   (If Yes to questions 4, 5 or 6, complete the boxes below.)
   The Producer shall comply with any additional state, and/or Company replacement requirements.

Person Proposed for Insurance	Company	Face Amount	Replaced/ Converted?	Pending?	1035 Exchange?	Business or Personal	Year Issued
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		

Proposed Insured(s) History

1. **Have you:** **(If answered Yes, please list details in the Comments section.)**	Proposed Insured	Other Proposed Insured
(a) had life insurance coverage declined, postponed or limited, or been denied reinstatement or asked to pay extra premium by any insurance company?	☐ Yes ☐ No	☐ Yes ☐ No
(b) engaged in parachuting, hang gliding, rock or mountain climbing, skydiving, SCUBA diving, cliff diving, organized vehicle or boat racing, BASE or bungee jumping within the last three years or plan such activity in the next two years? **(If Yes, complete the appropriate questionnaire.)**	☐ Yes ☐ No	☐ Yes ☐ No
(c) any intention of traveling or living outside the USA or Canada in the next two years? **(If Yes, complete the Foreign National and Foreign Travel questionnaire.)**	☐ Yes ☐ No	☐ Yes ☐ No
(d) flown as a civilian pilot, student pilot or crew member within the last three years or plan such activity in the next two years? **(If Yes, complete the Aviation questionnaire.)**	☐ Yes ☐ No	☐ Yes ☐ No
(e) within the last five years been convicted of two or more moving violations, been convicted of driving under the influence of alcohol or drugs or had a driver's license suspended or revoked?	☐ Yes ☐ No	☐ Yes ☐ No
(f) been convicted of or currently awaiting trial for a felony, or have been incarcerated within the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No

Comments

Provide any additional information necessary and the details of Yes answers. Identify the question number if applicable. Use an additional sheet of paper if necessary.

ICC116L660A

FULLY 13

Finances (Complete either the personal or business section)

Personal:

1. Purpose of Insurance:
   ☐ Income Replacement ☐ Debt Repayment ☐ Estate Conservation ☐ Other (Specify): ________________
2. Personal Finances: Gross Annual Income $______________ Total Assets $ _____________ Total Liabilities $ _____________
3. Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you?. . . ☐ **Yes** ☐ **No**
   If Yes, please explain and provide the filing and discharge dates____

Business: Please attach a copy of your Company's latest financial statements (Balance Sheet and Profit and Loss). If not available, complete the following questions:

1. Purpose of Insurance:
   ☐ Buy-Sell: Type of Agreement: ☐ Entity/Stock Redemption ☐ Cross Purchase ☐ Wait-and-See
   ☐ Key Person: Explanation of special skills/relationships to the business ___________________________________
   ____
   ☐ Other: Please Explain____
2. Proposed Insured's Salary (include bonus) $______________________
3. Company Book Value $________________________ Company Market Value $________________________
   Proposed Insured's % Ownership $_____________________Market Value of Proposed Insured's Ownership $__________________
4. Business Insurance Carried by Other Owners, Officers, Partners or Key Persons:

Name	Title and Interest	Amounts Now Carried and Company	Amount Now Applied For and Company

5. Within the past 5 years, has the business filed for bankruptcy or had any judgments or liens filed against it? . . ☐ **Yes** ☐ **No**
   If Yes, please explain and provide filing and discharge dates____

Agreement

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 temporary insurance agreement, 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.

This application includes Part 1, Part 2 and/or the Statements to Examiner as well as all approved supplemental forms or amendments the Insurer specifically designates as parts of the application, by attaching as part of any policy delivered to the Owner.

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.

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 Other Proposed Insured Age 15 and Over

____
Signature of Applicant/Owner/Trustee if other than Other 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 Insured is under Age 15

ICC116L660A

FULLY 13

Mutual of Omaha

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 PART 2, PAGE 1 OF 3

PROPOSED INSURED(S) INFORMATION

Name of Proposed Insured______	Name of Other Proposed Insured______
Date of Birth______	Date of Birth______
Height ______ft. ______in. Weight ______lbs.	Height ______ft. ______in. Weight ______lbs.

PHYSICIAN INFORMATION

Person Proposed for Insurance	Name, Address and Telephone Number of Personal Physician	Date Last Seen	State Reason, Findings and Treatment

FAMILY HISTORY

	Proposed Insured	Other Proposed Insured
Do you have a deceased parent(s) and/or sibling(s)? **(If Yes, please list details below. If more space is needed, use the Comments section.)**	☐ Yes ☐ No	☐ Yes ☐ No

	Age at Death	Cause of Death	Age at Death	Cause of Death
	Proposed Insured	Proposed Insured	Other Proposed Insured	Other Proposed Insured
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				

MEDICAL HISTORY

	Proposed Insured	Other Proposed Insured
1. Have you ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:		
(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, pacemaker or defibrillator, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke?	☐ Yes ☐ No	☐ Yes ☐ No
(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, sleep apnea or shortness of breath?	☐ Yes ☐ No	☐ Yes ☐ No
(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries?	☐ Yes ☐ No	☐ Yes ☐ No
(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	☐ Yes ☐ No	☐ Yes ☐ No
(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
(g) any disease, or disorder of vision, or hearing?	☐ Yes ☐ No	☐ Yes ☐ No
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/metabolic disorder?	☐ Yes ☐ No	☐ Yes ☐ No

INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 2 OF 3

Medical History Continued

	Proposed Insured	Other Proposed Insured
3. In the past 10 years, have you:		
(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?	☐ Yes ☐ No	☐ Yes ☐ No
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	☐ Yes ☐ No	☐ Yes ☐ No
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous? .	☐ Yes ☐ No	☐ Yes ☐ No
4. In the past 12 months, have you:		
(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?	☐ Yes ☐ No	☐ Yes ☐ No
(b) received, or been advised by a member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy?. .	☐ Yes ☐ No	☐ Yes ☐ No
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	☐ Yes ☐ No	☐ Yes ☐ No
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?	☐ Yes ☐ No	☐ Yes ☐ No
(e) had an unexplained weight loss of greater than 10 pounds (other than due to diet or exercise)?	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past two years, have you (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? . . . . **(If Yes, please list details below. If more space is needed use the Comments section.)**	☐ Yes ☐ No	☐ Yes ☐ No

Person Proposed for Insurance	Medication Name (copy from pharmacy label)	Date Last Taken	Prescribing Physician (if any)	Reason	Dosage/ Frequency

	Proposed Insured	Other Proposed Insured
6. In the past five years, have you consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? . . . . **(If Yes, please list details below. If more space is needed use the Comments section.)**	☐ Yes ☐ No	☐ Yes ☐ No

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

ICC116L661A

FULLY 13B

Comments

List details of Yes answers. Identify question number: Include diagnosis, dates, prescription medications, duration, and names and addresses of all attending physicians and medical facilities. Use an additional sheet of paper if necessary.

Agreement

I represent the information in this application 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.

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.

Signed at: ______________________________ City ______ State Date ______________ Mo Day Yr

____
Signature of Proposed Insured Age 15 and Over

____
Signature of Parent or Guardian if Proposed Insured is under Age 15

____
Signature of Other Proposed Insured Age 15 and Over

ICC116L661A

FULLY 13B

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

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** ______________________________

   ____

   ____

______________________________ ______________ ______________
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

Producer's Report

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

1 Is Proposed Primary Insured self-supporting? ❑ Yes ❑ No

If "No," provide the following information about the person on whom Proposed Primary Insured is dependent:

Full Name ______________________ Address ______________________ Birth Date __________

Amount of life insurance carried with all companies $ ____________ If none, state why______________________

2 If Proposed Primary Insured used a different name in past, give previous different full name(s) ______________________

____

3 Are you related to the Proposed Primary Insured or Owner? ❑ Yes ❑ No If answered "Yes," state relationship ___________

4 How long have you known the Proposed Primary Insured? ________________________

5 How long have you known the Proposed Owner? ________________________

6 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**

____

____

____

7 Will any entity other than a life insurance company evaluate the Proposed Life Insured(s) medically to determine life expectancy or to otherwise obtain financing? ❑ Yes ❑ No If "Yes," provide details ______________________

____

____

____

8 Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? ❑ Yes ❑ No

9 Rate class quoted ________________________________

10 Please check the Underwriting requirements ordered: ❑ Blood Profile/HOS ❑ Inspection Report ❑ MD Exam ❑ Treadmill EKG ❑ EKG ❑ Paramedical Exam Paramed Company ______________________

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

Address	From	To

Additional Comments

____

____

____

L8360

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

☐ Business owned by Proposed Insured/Insured or spouse

☐ Power of Attorney or legal guardian

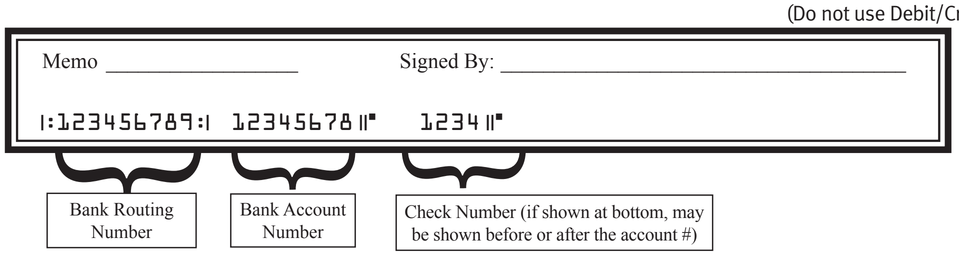
☐ Living Trust

☐ Other ____________________________________

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)



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

VERMONT AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB Inc., state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me and my children, if they are proposed insureds (My Children), to release Personal Information about me or My Children to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

The Personal Information will be used to determine my and My Children's eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual, or its reinsurers, to disclose my and My Children's personal Information to MIB, Inc. I understand that my and My Children's Personal Information received by MIB, Inc. 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.
NOTE: This authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC. I am NOT authorizing Mutual to forward the results from any new test requested by Mutual to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.

I understand that if the person or entity to whom Personal information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I understand if I refuse to sign, the insurance for which I am applying will not be issued.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Proposed Insured acknowledges and agrees that if there is more than one Proposed Insured on this application, all information provided may be reviewed or shared with the other Proposed Insured. A completed and signed application will become part of each insured's policy.

Name(s) used for medical records (if different than the name) below: ____________________

____

______________________________ **Date:** ____________
Signature of Proposed Insured — Mo Day Yr

______________________________ **Date:** ____________
Signature of Spouse (if Proposed Insured) — Mo Day Yr

______________________________ **Date:** ____________
Signature of Parent or Guardian (if Proposed Insured is a Minor) — Mo Day Yr

______________________________ **Date:** ____________
Signature of Non-minor Child (if Proposed Insured is a Non-minor) — Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

United of Omaha Life Insurance Company
A Mutual *of* Omaha Company

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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

Disclosure for Term Life Insurance Policies

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

Benefit Description

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 $1,000,000 or 80% of the policy's death benefit, whichever is less. A Terminal Illness is a medical condition that, within a reasonable degree of 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 an actuarial discount rate and a $100 charge. The actuarial discount rate will not be greater than 6%.

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. The Accelerated Death Benefit for Chronic Illness Rider is not available when the Long-Term Care Benefits Rider is issued.

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.

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 an actuarial discount rate and a $100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount rate will not be greater than 6%.

Benefit Description - Accelerated Death Benefit for Chronic Illness Rider - (This rider is not available when the Long-Term Care Benefits Rider is issued.)

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 and safety due to severe cognitive impairments.

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 an actuarial discount rate multiplied by the insured's life expectancy in years, a $100 charge, and the pro-rated amount of any outstanding loans.

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 ______________

Temporary Life Insurance Agreement ("Agreement")

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

If any proposed insured dies while coverage under this agreement is in effect, we will pay to the beneficiary(ies) named in the application the temporary insurance Benefit ("TIA Benefit") described in the section below entitled "Benefit".

Questions

If any question listed below is answered "Yes" or left blank, NO COVERAGE will take effect under this Agreement.

The questions below apply to **all** Proposed Insured(s) shown on the application.

	YES	NO
1 Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, had surgery performed or recommended, or been advised by a member of the medical profession to be admitted or to have a diagnostic test other than an HIV test?	☐	☐
2 Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider?	☐	☐
3 Has any Proposed Insured ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
4 Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐
5 Does amount applied for exceed $1,000,000?	☐	☐
6 Is the policy applied for a second to die life insurance policy?	☐	☐

No Coverage

There is NO temporary insurance coverage if:

1 No premium is submitted at the time this Agreement is submitted or if the premium check or electronic transaction is not honored;or
2 Any question listed above is answered "Yes" or left blank; or
3 There is a material misrepresentation in any answer to any question listed above or to any questions or statements in the application and/or any questionnaires and supplements to the application; or
4 Internal Revenue Code section 1035 exchange paperwork is received without full initial modal premium; or
5 A Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, in which case, United will not be liable under this Agreement except to return any payment paid with the application.

Benefit

For purposes of this Agreement, the TIA Benefit is an amount equal to the lesser of: (1) the amount of insurance applied for in the application; or (2) $1,000,000 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 TIA Benefit under this Agreement exceed $1,000,000.

Start Date

Any Temporary insurance coverage provided **STARTS** on the date all of the following requirements have been met:

1 This Agreement has been fully completed, signed and dated on the date of the application by the Proposed Insured(s), Applicant/Owner and Producer.
2 The full initial modal premium is received at our Home Office and made by check or authorized electronic transaction. A payment will be considered to be received only if one of the following valid items is received at our Home Office: (a) a check made payable to United of Omaha in the amount of the full first required premium; or (b) a completed and signed electronic transaction authorization for the first full premium.
3 All application information (including, but not limited to, all information necessary to complete the application and/or any questionnaires and supplements to the application) and any medical exam and tests required by United are completed. Notwithstanding the preceding sentence, if the Proposed Insured dies within 30 days after the date this Agreement is signed as a direct result of, independent from all other causes, accidental bodily injury that occurs after the date of this Agreement but before any medical exam and tests are completed, we will pay to the beneficiary(ies) named in the application the TIA Benefit.

End Date

This Agreement and any coverage provided hereunder will **END** on the earliest of the following dates:

1 90 days from the date of this Agreement; or
2 The date we deliver the policy applied for to the applicant/owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at a standard risk class; or (b) have declined to issue you a policy; or (c) will not provide temporary insurance coverage; or
4 The date the applicant/owner withdraws the application for insurance.

Signatures

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement 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.
I/We have read and received a copy of this Agreement 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 knowledege and belief. I/We understand that the Producer has no authority to change the terms of this Agreement.

Signature of Proposed Insured ____________________ Date ____________________

Signature of Other Proposed Insured ____________________ Date ____________________

Signature of Applicant/Owner (if other than Proposed Insured) ____________________ Date ____________________

Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized $____________________

I/We have not received a check with the application if any question in the above section entitled "Questions" was answered "yes" or left blank. I/We agree that I/We am/are not authorized to change or waive the terms of this Agreement and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Agreement to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

Signature of Producer ____________________ Date ____________________

Signature of Producer ____________________ 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.

X ______________________ Signature of Applicant A	________ Date
X ______________________ Signature of Applicant B	________ Date

M28704

HIV Testing Information Statement & Consent Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep and review.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for indication of HIV infection. This information may be used as part of its decision whether to sell you insurance coverage. The insurance company may request a sample of your blood in order to conduct the test. The insurance company will pay for this test.

HIV stands for human immunodeficiency virus. HIV is the virus that causes AIDS (acquired immunodeficiency syndrome). Different laboratory tests can be used to identify HIV infection, the most common being a combination HIV antibody/antigen test. Presence of HIV antibodies or antigens in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody/antigen test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS and more testing is needed to assess your health. A negative test result means that no HIV antibodies or antigens were found. Because of varying incubation periods (also known as the window period), absence of HIV antibodies or antigens does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies or antigens does not mean that you are immune to the virus. If your HIV antibody/antigen test is indeterminate, a nucleic acid test (NAT) may be ordered to provide more information. More information about the HIV testing process specific to the insurance company you are applying to can be requested of their medical staff.

If after listening to this statement you do not wish to be tested, do not sign the informed consent form and the application process will be suspended. Before deciding whether to consent to this testing you may, at your own choice and expense, consult with a personal physician or counselor or the Vermont Department of Health regarding HIV and HIV testing. Anonymous HIV testing is also available, the results of which would not be connected to any personally identifying information. To find an anonymous HIV testing site contact the Vermont Department of Health using the contact information at the end of this letter. Any delay in your application resulting from pursuing the options described above will not affect the status of your application or policy.

If after listening to this statement you decide to proceed, you may choose to receive the test results directly or to designate in writing (on the informed consent form) any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the insurance company, which may in turn report results to its affiliates, reinsurers, medical personnel and insurance support organizations that are involved in the decision by the insurer to sell you insurance. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or knowing disclosure of HIV-related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to the medical information bureau (MIB). The MIB is a central computerized facility that keeps on file the health information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health.

You have rights that include the following:

1. If your HIV status is determined to be negative, coverage shall not be denied based on HIV status.
2. Your HIV test will only be considered as positive if testing results meet the most current Centers for Disease Control and Prevention recommended laboratory HIV testing algorithm or more reliable confirmatory test or test protocol that has been approved by the United States Food and Drug Administration.
3. If the HIV-1/2 antibody differentiation test result is indeterminate, the insurer may delay action on the application, but no change in preexisting coverage, benefits, or rates under any separate policy or policies held by the individual shall be based upon such indeterminacy.

4. If the HIV-1 NAT test is invalid, the full testing algorithm shall be repeated.

5. No application for coverage shall be denied based on an indeterminate or invalid result. Any underwriting decision granting a substandard classification or exclusion based on the individual's prior HIV-related test results shall be reversed, and the company performing any previous HIV-related testing that had forwarded to a medical information bureau reports based upon the individual's prior HIV-related test results shall request the medical information bureau to remove any abnormal codes listed due to such prior test results.

6. If you are denied insurance, or offered insurance on any other than a standard basis, because of the positive results of an HIV-related test, you may request a retest once within the three-year period following the date of the most recent test; and in any event, upon updates to the Centers for Disease Control and Prevention recommended laboratory HIV testing algorithm for serum or plasma specimens. If such retest is negative, a new application for coverage shall not be denied by the insurer based upon the results of the initial test. Any underwriting decision granting a substandard classification or exclusion based on the individual's prior HIV-related test results shall be reversed, and the company performing a retest which had forwarded to a medical information bureau reports based upon the individual's prior HIV-related test results shall request the medical information bureau to remove any abnormal codes listed due to such prior test results.

7. Any individual who sustains damage as a result of the unauthorized negligent or knowing disclosure of that individual's individually-identifiable HIV-related test result information in violation of subdivision (H) of this subdivision (20) may bring an action for appropriate relief in Superior Court against any person making such a disclosure. The Court may award costs and reasonable attorney's fees to the individual who prevails in an action brought under this subdivision.

Information about HIV and how to access anonymous HIV testing sites in Vermont is available at the Vermont Department of Health website: www.healthvermont.gov/disease-control/hiv or by calling (800) 882-2437. Additional information about HIV is available at the Centers for Disease Control and Prevention’s website www.cdc.gov/hiv or by calling (800) 232-4636.

HIV is a treatable infection. In the event you test positive for HIV, it is very important that you seek medical care. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437.

If you choose, you will now be asked to sign a written informed consent form permitting the insurance company to have you tested for HIV.

Informed Consent

To be signed before medical professional or company agent obtains sample.

This statement has been read aloud to me and I understand this HIV TESTING INFORMATION STATEMENT & CONSENT FORM. I voluntarily consent to the collection of blood samples for the purpose of testing to determine if HIV antibodies or antigens are present and the disclosure of the test results as described above.

____________________ ____________________

Name of Proposed Insured Signature of Proposed Insured Date

____________________ Witness ____________________

Birth Date State of Residence (Agent Signature)

Notification of Test Results

To be completed at time of application or when a Medical Professional or company agent obtains sample.
You may choose to receive the test results directly or to designate below another person to whom the results should be sent:
PLEASE SEND MY TEST RESULTS TO:

Name ____________________

Address ____________________

City ____________________ State __________ Zip Code __________

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

Third Party Notice

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. This extra notice will be sent at least 21 days prior to the effective date of cancellation of your policy or certificate only if you are age 64 or older. This notice will state the amount of premium, the date by when the premium must be paid and the date on which coverage terminates. 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.

PLEASE COMPLETE EITHER SECTION 1 OR SECTION 2 AND RETURN TO US.

Section 1

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 ______________________________

Section 2

I do not wish to designate an additional person to receive notice of nonpayment of premium.

Signature of Policyowner/Certificateholder

____

Date ______________________________

UNITED *of* OMAHA LIFE INSURANCE COMPANY Attn: Individual Life Underwriting, Mutual of Omaha Plaza, Omaha, NE, 68175

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 TIA to the client if a check or electronic transaction for the initial premium was not collected at the time of application.**

Replacement Notices
If replacing, you and the applicant must sign the customer copy of the replacement notice.

For those states that use **Form L6232_**:
This form must be completed if any existing coverage is listed on the application in the "Other Coverage Section," even if this is not a replacement.

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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

DISCLOSURE FOR TERM LIFE INSURANCE POLICIES

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

BENEFIT DESCRIPTION

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 $1,000,000 or 80% of the policy's death benefit, whichever is less. A Terminal Illness is a medical condition that, within a reasonable degree of 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 an actuarial discount rate and a $100 charge. The actuarial discount rate will not be greater than 6%.

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. The Accelerated Death Benefit for Chronic Illness Rider is not available when the Long-Term Care Benefits Rider is issued.

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.

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 an actuarial discount rate and a $100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount rate will not be greater than 6%.

BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER -(THIS RIDER IS NOT AVAILABLE WHEN THE LONG-TERM CARE BENEFITS RIDER IS ISSUED.)

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 and safety due to severe cognitive impairments.

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 an actuarial discount rate multiplied by the insured's life expectancy in years, a $100 charge, and the pro-rated amount of any outstanding loans.

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 _______________

ACCUMUL ANSWERS, TLA, INCOME ADVANTAGE, LIFE PROTECTION ADVANTAGE, PROFESSIONAL ADVANTAGE

HIV Testing Information Statement & Consent Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep and review.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for indication of HIV infection. This information may be used as part of its decision whether to sell you insurance coverage. The insurance company may request a sample of your blood in order to conduct the test. The insurance company will pay for this test.

HIV stands for human immunodeficiency virus. HIV is the virus that causes AIDS (acquired immunodeficiency syndrome). Different laboratory tests can be used to identify HIV infection, the most common being a combination HIV antibody/antigen test. Presence of HIV antibodies or antigens in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody/antigen test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS and more testing is needed to assess your health. A negative test result means that no HIV antibodies or antigens were found. Because of varying incubation periods (also known as the window period), absence of HIV antibodies or antigens does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies or antigens does not mean that you are immune to the virus. If your HIV antibody/antigen test is indeterminate, a nucleic acid test (NAT) may be ordered to provide more information. More information about the HIV testing process specific to the insurance company you are applying to can be requested of their medical staff.

If after listening to this statement you do not wish to be tested, do not sign the informed consent form and the application process will be suspended. Before deciding whether to consent to this testing you may, at your own choice and expense, consult with a personal physician or counselor or the Vermont Department of Health regarding HIV and HIV testing. Anonymous HIV testing is also available, the results of which would not be connected to any personally identifying information. To find an anonymous HIV testing site contact the Vermont Department of Health using the contact information at the end of this letter. Any delay in your application resulting from pursuing the options described above will not affect the status of your application or policy.

If after listening to this statement you decide to proceed, you may choose to receive the test results directly or to designate in writing (on the informed consent form) any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the insurance company, which may in turn report results to its affiliates, reinsurers, medical personnel and insurance support organizations that are involved in the decision by the insurer to sell you insurance. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or knowing disclosure of HIV-related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to the medical information bureau (MIB). The MIB is a central computerized facility that keeps on file the health information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health.

You have rights that include the following:

1. If your HIV status is determined to be negative, coverage shall not be denied based on HIV status.
2. Your HIV test will only be considered as positive if testing results meet the most current Centers for Disease Control and Prevention recommended laboratory HIV testing algorithm or more reliable confirmatory test or test protocol that has been approved by the United States Food and Drug Administration.
3. If the HIV-1/2 antibody differentiation test result is indeterminate, the insurer may delay action on the application, but no change in preexisting coverage, benefits, or rates under any separate policy or policies held by the individual shall be based upon such indeterminacy.

4. If the HIV-1 NAT test is invalid, the full testing algorithm shall be repeated.

5. No application for coverage shall be denied based on an indeterminate or invalid result. Any underwriting decision granting a substandard classification or exclusion based on the individual's prior HIV-related test results shall be reversed, and the company performing any previous HIV-related testing that had forwarded to a medical information bureau reports based upon the individual's prior HIV-related test results shall request the medical information bureau to remove any abnormal codes listed due to such prior test results.

6. If you are denied insurance, or offered insurance on any other than a standard basis, because of the positive results of an HIV-related test, you may request a retest once within the three-year period following the date of the most recent test; and in any event, upon updates to the Centers for Disease Control and Prevention recommended laboratory HIV testing algorithm for serum or plasma specimens. If such retest is negative, a new application for coverage shall not be denied by the insurer based upon the results of the initial test. Any underwriting decision granting a substandard classification or exclusion based on the individual's prior HIV-related test results shall be reversed, and the company performing a retest which had forwarded to a medical information bureau reports based upon the individual's prior HIV-related test results shall request the medical information bureau to remove any abnormal codes listed due to such prior test results.

7. Any individual who sustains damage as a result of the unauthorized negligent or knowing disclosure of that individual's individually-identifiable HIV-related test result information in violation of subdivision (H) of this subdivision (20) may bring an action for appropriate relief in Superior Court against any person making such a disclosure. The Court may award costs and reasonable attorney's fees to the individual who prevails in an action brought under this subdivision.

Information about HIV and how to access anonymous HIV testing sites in Vermont is available at the Vermont Department of Health website: www.healthvermont.gov/disease-control/hiv or by calling (800) 882-2437. Additional information about HIV is available at the Centers for Disease Control and Prevention's website www.cdc.gov/hiv or by calling (800) 232-4636.

HIV is a treatable infection. In the event you test positive for HIV, it is very important that you seek medical care. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437.

If you choose, you will now be asked to sign a written informed consent form permitting the insurance company to have you tested for HIV.

Informed Consent

To be signed before medical professional or company agent obtains sample.

This statement has been read aloud to me and I understand this HIV TESTING INFORMATION STATEMENT & CONSENT FORM. I voluntarily consent to the collection of blood samples for the purpose of testing to determine if HIV antibodies or antigens are present and the disclosure of the test results as described above.

Name of Proposed Insured ____________________

Signature of Proposed Insured ____________________ Date

Birth Date ____________ State of Residence ____________

Witness ____________________
(Agent Signature)

Notification of Test Results

To be completed at time of application or when a Medical Professional or company agent obtains sample.
You may choose to receive the test results directly or to designate below another person to whom the results should be sent:
PLEASE SEND MY TEST RESULTS TO:

Name ____________________

Address ____________________

City ____________ State ____________ Zip Code ____________

Temporary Life Insurance Agreement ("Agreement")

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

If any proposed insured dies while coverage under this agreement is in effect, we will pay to the beneficiary(ies) named in the application the temporary insurance Benefit ("TIA Benefit") described in the section below entitled "Benefit".

Questions

If any question listed below is answered "Yes" or left blank, NO COVERAGE will take effect under this Agreement.

The questions below apply to **all** Proposed Insured(s) shown on the application.

	YES	NO
1 Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, had surgery performed or recommended, or been advised by a member of the medical profession to be admitted or to have a diagnostic test other than an HIV test?	☐	☐
2 Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider?	☐	☐
3 Has any Proposed Insured ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
4 Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐
5 Does amount applied for exceed $1,000,000?	☐	☐
6 Is the policy applied for a second to die life insurance policy?	☐	☐

No Coverage

There is NO temporary insurance coverage if:

1 No premium is submitted at the time this Agreement is submitted or if the premium check or electronic transaction is not honored;or
2 Any question listed above is answered "Yes" or left blank; or
3 There is a material misrepresentation in any answer to any question listed above or to any questions or statements in the application and/or any questionnaires and supplements to the application; or
4 Internal Revenue Code section 1035 exchange paperwork is received without full initial modal premium; or
5 A Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, in which case, United will not be liable under this Agreement except to return any payment paid with the application.

Benefit

For purposes of this Agreement, the TIA Benefit is an amount equal to the lesser of: (1) the amount of insurance applied for in the application; or (2) $1,000,000 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 TIA Benefit under this Agreement exceed $1,000,000.

Start Date

Any Temporary insurance coverage provided **STARTS** on the date all of the following requirements have been met:

1 This Agreement has been fully completed, signed and dated on the date of the application by the Proposed Insured(s), Applicant/Owner and Producer.
2 The full initial modal premium is received at our Home Office and made by check or authorized electronic transaction. A payment will be considered to be received only if one of the following valid items is received at our Home Office: (a) a check made payable to United of Omaha in the amount of the full first required premium; or (b) a completed and signed electronic transaction authorization for the first full premium.
3 All application information (including, but not limited to, all information necessary to complete the application and/or any questionnaires and supplements to the application) and any medical exam and tests required by United are completed. Notwithstanding the preceding sentence, if the Proposed Insured dies within 30 days after the date this Agreement is signed as a direct result of, independent from all other causes, accidental bodily injury that occurs after the date of this Agreement but before any medical exam and tests are completed, we will pay to the beneficiary(ies) named in the application the TIA Benefit.

End Date

This Agreement and any coverage provided hereunder will **END** on the earliest of the following dates:

1 90 days from the date of this Agreement; or
2 The date we deliver the policy applied for to the applicant/owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at a standard risk class; or (b) have declined to issue you a policy; or (c) will not provide temporary insurance coverage; or
4 The date the applicant/owner withdraws the application for insurance.

Signatures

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement 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.

I/We have read and received a copy of this Agreement 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 knowledege and belief. I/We understand that the Producer has no authority to change the terms of this Agreement.

Signature of Proposed Insured ____________________ Date ____________________

Signature of Other Proposed Insured ____________________ Date ____________________

Signature of Applicant/Owner (if other than Proposed Insured) ____________________ Date ____________________

Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized $____________

I/We have not received a check with the application if any question in the above section entitled "Questions" was answered "yes" or left blank. I/We agree that I/We am/are not authorized to change or waive the terms of this Agreement and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Agreement to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

Signature of Producer ____________________ Date ____________________

Signature of Producer ____________________ Date ____________________

MUTUAL OF OMAHA INSURANCE COMPANY
UNITED OF OMAHA LIFE INSURANCE COMPANY

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.

X		X	
Signature of Applicant A	Date	Signature of Applicant B	Date

M28704

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.

Investigative Consumer Reports Notice

Mutual of Omaha Insurance Company and/or United of Omaha Life Insurance Company, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will inform you whether an investigative consumer report was requested, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

If you request any additional disclosures from either Mutual of Omaha Insurance Company or United of Omaha Life Insurance Company, please send your request to the following address: Attention: Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, NE 68175. Following this Notice is a written Summary of Your Rights under Section 609(c) of the Fair Credit Reporting Act, as amended.

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, D.C. 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identify theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.
- In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights contact:

TYPE OF BUSINESS:	CONTACT:
1. a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates **b.** Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB	**a.** Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552 **b.** Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: **a.** National banks, federal savings associations and federal branches and federal agencies of foreign bank **b.** State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act **c.** Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations **d.** Federal Credit Unions	**a.** Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 **b.** Federal Reserve Consumer Help Center PO Box 1200 Minneapolis, MN 55480 **c.** FDIC Consumer Response Center 1100 Walnut St., Box #11 Kansas City, MO 64106 **d.** National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W. Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area Supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E. Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 (877) 382-4357

GIVE THIS COPY TO THE APPLICANT

Mutual of Omaha

Fit Test

Name: ______________________________

Date: ______________________________

Complete with ALL Fully Underwritten Term and UL Applications

Requirements

- Ages 18-75
- Minimum face amount: $100,000
- Maximum face amount: $5,000,000 Total coverage in force and applied for with United of Omaha Life Insurance Company
- Nontobacco users
- Base rating *after* normal credits of table 4 or less
- Does not apply to "flat extra" ratings or those with current rateable substance abuse histories, CAD prior to age 50, stroke, rateable cancers, Type 1 diabetes or Human Immunodeficiency Virus (HIV)

If your client has several of the following characteristics they may qualify for up to an *additional two table credits* from the base rating on both fully underwritten term and permanent insurance.

Note: No more than two lifestyle characteristics can be applied toward credits

3 Characteristics = 1 table credit   5 Characteristics = 2 table credits

Lifestyle Characteristics

Check all that apply

Regular preventative medical care and compliant follow-up for treated impairments within past 12 months? ☐ **Yes**
No tobacco use for past 10 years? ☐ **Yes**
Income › $100,000 or net worth › $1,000,000? ☐ **Yes**
Preferred or better driving record? ☐ **Yes**

Medical Characteristics

Great family history – no deaths from any disease prior to age 70? ☐ **Yes**
Cholesterol/HDL ratio under 5.0? ☐ **Yes**
A1c test ‹ 5.7? ☐ **Yes**
Serum albumin › 4.2 ages 61-75? ☐ **Yes**
Negative cardiac testing: GXT, non-imaged or imaged (stress echo, perfusion study), echocardiogram, EBCT or angiography (within the past 2 years)? ☐ **Yes**
GXT exercise performance over 10 METS (within the past 2 years)? ☐ **Yes**
Optimal blood pressure control-treated or untreated with average of 135/85 or better? ☐ **Yes**
Preferred or better build, ages 18-60. Standard plus or better build, ages 61-75? ☐ **Yes**
BNP ‹100 ages 61-75? ☐ **Yes**
Normal CBC ages 61-75? ☐ **Yes**

If you answered yes to 3 or more of these questions, you may qualify for additional table credits.

Submit with Application

219056_0123

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

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:

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

Policy Values:

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

Insurability:

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

If you are keeping the old policy as well as the new policy:

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

If you are surrendering an annuity or interest sensitive life product:

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

Other issues to consider for all transactions:

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

GIVE THIS COPY TO THE APPLICANT

THIS REPLACEMENT FORM REQUIRED IF APPLICANT/OWNER HAS ANY EXISTING LIFE OR ANNUITY CONTRACTS

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.)

THIS REPLACEMENT FORM REQUIRED IF APPLICANT/OWNER HAS ANY EXISTING LIFE OR ANNUITY CONTRACTS

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.)

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: ____

____

____

Name of Insured

Name of Agent	Production Number	Phone Number	Email Address

Next Highest Upline	Production Number	Phone Number	Email Address

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

____

____

____

____

____

____