

NATIONAL - Application for Children's Whole Life Insurance



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

Application Submission Guidelines

- Attach a cover letter or additional information as needed.
- Leave all applicable forms and Life Insurance Buyer's Guide with the Proposed Insured.
- Please make sure all questions are answered and signatures completed.
- All changes should be initialed and dated by the Owner/Applicant.
- If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

Important Forms

- Replacement Notice - if applicable, the client must sign and retain a copy for their records
- Payment Authorization - Complete this form if applicable



LAP1134
01/22/2018



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3300 Mutual of Omaha Plaza
 Omaha, Nebraska 68175



APPLICATION FOR CHILDREN'S WHOLE LIFE INSURANCE

SECTION A OWNER/APPLICANT

Owner/Applicant Name (First Name, Initial, Last Name)		Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address (Street, City, State, ZIP)		Date of Birth (Month, Day Year)	
Phone Number	E-mail Address		
Are you a legal permanent resident of the United States?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION B BENEFICIARY

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

If more space is needed, attach a sheet for additional details.

SECTION C SECONDARY ADDRESSEE (OPTIONAL) - THIS PERSON WILL RECEIVE COPIES OF OVERDUE PREMIUM AND LAPSE NOTICES.

Name (First Name, Initial, Last Name)	Phone Number
Address (Street, City, State, ZIP)	

SECTION D PROPOSED INSURED(S) INFORMATION (LIST CHILDREN AGES 14 DAYS TO 17 YEARS)

First Name, Middle Initial, Last Name	Date of Birth	Sex M/F	Coverage Amount	Premium	Owner Relationship to Insured	Legal Permanent Resident of the United States?
				\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$		<input type="checkbox"/> Yes <input type="checkbox"/> No
				\$		<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: Use additional sheet if necessary.

SECTION E OTHER COVERAGE AND REPLACEMENT INFORMATION

Do any of the Proposed Insureds:

1. have any existing life insurance or annuity contracts with the company or any other company?..... Yes No

2. intend for this insurance to replace or change any existing life insurance or annuity contract with the company or any other company? Yes No

IF "YES" to either question, GIVE DETAILS BELOW:

Proposed Insured's Name	Company	Policy Number	Will this insurance be replaced?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

THE PRODUCER SHALL COMPLY WITH ANY ADDITIONAL STATE AND/OR COMPANY REPLACEMENT REQUIREMENTS.

ICC17L663A

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

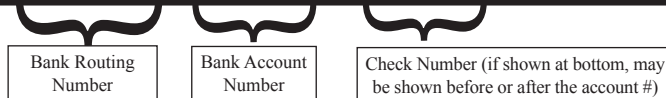
2. Name of Financial Institution: _____

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

Bank Routing Number: _____ Bank Account Number: _____

(Do not use Debit/Credit Card numbers)

Memo _____	Signed By: _____
⑆123456789⑆ 12345678 ⑆ 1234 ⑆	



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

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?





HIPAA AUTHORIZATION RELEASE TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured

Please Print

_____ / ____ / ____
First MI Last DOB Month/Day/Year

I authorize any person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer report agency, state motor vehicle agency, employer, or any other person or institution to release to each of the insurance companies listed below, as well as to their reinsures, any insurance support organizations, those person authorized to represent them; and International Brokerage Agencies, Inc.; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputations, finances, occupations, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

- Aetna Companies
- Allstate Health Solutions
- American National
- APPS
- Brighthouse Life
- Corebridge
- ExamOne
- Express Imaging Services
- Fidelity Life
- Gerber
- Global Atlantic
- Illinois Mutual
- IMG
- J&H
- John Hancock
- Kemper
- Legal & General
- Lincoln Financial Group
- MassMutual
- Mutual of Omaha
- Nationwide
- North American
- OneAmerica
- Pacific Life
- Principal Life
- Protective
- Prudential
- SBLI
- Securian Financial
- Symetra
- Transamerica
- World Trips

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPPA protected health information do not apply for purposes of this authorization and I instruct my physician, health care professional, hospital, clinic, medical facility or any other health care provider to release and disclose my entire medical record without restriction to International Brokerage Agencies, Inc. I understand that any information that it is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, disability income, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies listed above and their re-insurers as well as International Brokerage Agencies, Inc. and its staff, employees and affiliated companies.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall be valid for twenty-four (24) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand I may revoke this authorization in writing at any time by providing that written notification to International Brokerage Agencies, Inc. at the service address below. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand that if I refuse to sign this authorization, International Brokerage Agencies, Inc. may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health services if I refuse to sign this authorization.

Signature of Proposed Insured

Name of Proposed Insured

City

State

Month/Day/Year