



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

TEXAS – 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
<input type="checkbox"/> Term Life Answers (TLA)	<input type="checkbox"/> Disability Waiver of Premium Rider <input type="checkbox"/> Other Insured Rider <input type="checkbox"/> Dependent Children's Rider (\$1,000 - \$10,000) <input type="checkbox"/> Accidental Death Benefits Rider
<input type="checkbox"/> AccumUL Answers <input type="checkbox"/> Income Advantage (IUL) <input type="checkbox"/> Life Protection Advantage (IUL)	<input type="checkbox"/> Disability Waiver of Policy Charges <input type="checkbox"/> Disability Continuation of Planned Premium Rider <input type="checkbox"/> Guaranteed Insurability Rider (\$10,000-\$50,000) <input type="checkbox"/> Dependent Children's Rider (\$1,000 - \$10,000) <input type="checkbox"/> Accidental Death Benefit Rider <input type="checkbox"/> Additional Insured Term Rider - Self & Other Insured <input type="checkbox"/> Long-Term Care Benefits Rider (Income Advantage & Life Protection Advantage Only)

APPLICATION SUBMISSION GUIDELINES
<input type="checkbox"/> Attach a cover letter or additional information as needed, and Always submit the Producer Statement and Producer Report page <input type="checkbox"/> Always obtain signed HIPAA/MIB authorization <input type="checkbox"/> Leave all applicable forms and Life Insurance Buyer's Guide with the Proposed Insured <input type="checkbox"/> All changes should be initialed and dated by the Applicant/Owner <input type="checkbox"/> If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client <input type="checkbox"/> 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
<input type="checkbox"/> Replacement Notice - If applicable, the client must sign and retain a copy for their records <input type="checkbox"/> Payment Authorization - Complete this form if applicable <input type="checkbox"/> 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. <input type="checkbox"/> You will need a signed Accelerated Death Benefit Rider Disclosure Form <input type="checkbox"/> 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) <input type="checkbox"/> 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 <input type="checkbox"/> 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. <input type="checkbox"/> 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
<ul style="list-style-type: none"> ● 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 <input type="checkbox"/> Blood Profile <input type="checkbox"/> Urinalysis <input type="checkbox"/> Physical Data <input type="checkbox"/> MD Exam <input type="checkbox"/> Long Form Exam <input type="checkbox"/> EKG <input type="checkbox"/> Treadmill EKG	Other Proposed Insured: <input type="checkbox"/> Blood Profile <input type="checkbox"/> Urinalysis <input type="checkbox"/> Physical Data <input type="checkbox"/> MD Exam <input type="checkbox"/> Long Form Exam <input type="checkbox"/> EKG <input type="checkbox"/> Treadmill EKG





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 <input type="checkbox"/> Male <input type="checkbox"/> 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?... <input type="checkbox"/> Yes <input type="checkbox"/> 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?... <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> 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?... <input type="checkbox"/> Yes <input type="checkbox"/> 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?... <input type="checkbox"/> Yes <input type="checkbox"/> 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

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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
			<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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If Yes, complete the appropriate questionnaire.)		
(c) any intention of traveling or living outside the USA or Canada in the next two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If Yes, complete the Foreign National and Foreign Travel questionnaire.)		
(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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(If Yes, complete the Aviation questionnaire.)		
(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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) been convicted of or currently awaiting trial for a felony, or have been incarcerated within the last 10 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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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	

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 A Mutual of Omaha Company

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 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

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.)	Proposed Insured	Other Proposed Insured
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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)?	Proposed Insured	Other Proposed Insured
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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? (b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, sleep apnea or shortness of breath? (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? (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? (e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia? (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? (g) any disease, or disorder of vision, or hearing? (h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/metabolic disorder?	Proposed Insured	Other Proposed Insured
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 2 OF 3

MEDICAL HISTORY CONTINUED

<p>3. In the past 10 years, have you:</p> <p>(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?</p> <p>(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?</p> <p>(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous? .</p>	Proposed Insured	Other Proposed Insured
	<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
<p>4. In the past 12 months, have you:</p> <p>(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?</p> <p>(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? .</p> <p>(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?</p> <p>(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?</p> <p>(e) had an unexplained weight loss of greater than 10 pounds (other than due to diet or exercise)? .</p>	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>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?</p> <p>(If Yes, please list details below. If more space is needed use the Comments section.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

<p>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?</p> <p>(If Yes, please list details below. If more space is needed use the Comments section.)</p>	Proposed Insured	Other Proposed Insured
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 3 OF 3

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: _____ Date _____
City State 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

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PRODUCER STATEMENT

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

If "Yes," give name(s) of the person(s) _____

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

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

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

If "No," please explain _____

5. I conducted said interview in person Yes No If "No," please explain _____

 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



UNITED OF OMAHA LIFE INSURANCE COMPANY

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



PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: _____ Policy Number(s) if known: _____

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

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

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

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

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

PAYMENT INFORMATION FOR ONGOING PAYMENTS- AUTOMATIC BANK ACCOUNT DEDUCTION

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

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

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

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

PAYOR INFORMATION

Name of payor as shown on bank account: _____

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

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

PAYOR ACCOUNT INFORMATION

1. Account Type (check one): Checking Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check here.
Bank Routing Number: _____ Bank Account Number: _____
(Do not use Debit/Credit Card numbers)

Memo _____	Signed By: _____	
Bank Routing Number	Bank Account Number	Check Number (if shown at bottom, may be shown before or after the account #)

PAYOR AUTHORIZATION

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

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



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

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.

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: _____

 Signature of Proposed Insured

Date: _____
 Mo Day Yr

 Signature of Spouse (if Proposed Insured)

Date: _____
 Mo Day Yr

 Signature of Parent or Guardian (if Proposed Insured is a Minor)

Date: _____
 Mo Day Yr

 Signature of Non-minor Child (if Proposed Insured is a Non-minor)

Date: _____
 Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

L8232_0913





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%

Acknowledgment

I acknowledge receipt of this Disclosure Form



Applicant/Owner Signature

Date

I have provided this Disclosure Form to the Applicant



Producer Signature

Date

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.

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? <input type="checkbox"/> <input type="checkbox"/>
	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? <input type="checkbox"/> <input type="checkbox"/>
	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)?..... <input type="checkbox"/> <input type="checkbox"/>
	4	Is any Proposed Insured under 15 days old or over 70 years of age?..... <input type="checkbox"/> <input type="checkbox"/>
5	Does amount applied for exceed \$1,000,000? <input type="checkbox"/> <input type="checkbox"/>	
6	Is the policy applied for a second to die life insurance policy? <input type="checkbox"/> <input type="checkbox"/>	

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.
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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.	

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 knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Agreement.

SIGNATURES	Signature of Proposed Insured _____ Date _____
	Signature of Other Proposed Insured _____ Date _____
	Signature of Applicant/Owner (if other than Proposed Insured) _____ Date _____
	Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> 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
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Notice and Consent for HIV-Related Testing



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

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Results

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application.

The result may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result _____

Address _____

In the event that the test is positive and you are denied coverage because of that fact, and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this Notice and Consent for HIV-related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test result as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed Insured or Parent/Guardian Name of Proposed Insured Date

Address



PLEASE SUBMIT

MLU16923_1002



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

Summary of Premium Provisions Statement of Understanding

The policy you have applied for is indeterminate premium insurance.

I understand that the premiums for the policy for which I am applying are guaranteed for only:

TERM LIFE ANSWERS	TERM LIFE ANSWERS	TERM LIFE ANSWERS
<input type="checkbox"/> 10 years	<input type="checkbox"/> 15 years	<input type="checkbox"/> 20 years

I further understand that the current schedule of premiums may change after the guaranteed period checked above. After that period, premiums may stay the same, go down, or go up, but will never be higher than the guaranteed maximum premiums. Any changes in premiums will be made on a policy anniversary.

Name of Applicant/Owner: _____

Date: _____

Signature of Applicant/Owner: _____



Company's Copy

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%

Acknowledgment

I acknowledge receipt of this Disclosure Form



Applicant/Owner Signature

Date

I have provided this Disclosure Form to the Applicant



Producer Signature

Date

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.



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

Summary of Premium Provisions Statement of Understanding

The policy you have applied for is indeterminate premium insurance.

I understand that the premiums for the policy for which I am applying are guaranteed for only:

TERM LIFE ANSWERS	TERM LIFE ANSWERS	TERM LIFE ANSWERS
<input type="checkbox"/> 10 years	<input type="checkbox"/> 15 years	<input type="checkbox"/> 20 years

I further understand that the current schedule of premiums may change after the guaranteed period checked above. After that period, premiums may stay the same, go down, or go up, but will never be higher than the guaranteed maximum premiums. Any changes in premiums will be made on a policy anniversary.

Name of Applicant/Owner: _____

Date: _____

Signature of Applicant/Owner: _____



Applicant's Copy

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? <input type="checkbox"/> <input type="checkbox"/>
	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? <input type="checkbox"/> <input type="checkbox"/>
	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)?..... <input type="checkbox"/> <input type="checkbox"/>
	4	Is any Proposed Insured under 15 days old or over 70 years of age?..... <input type="checkbox"/> <input type="checkbox"/>
5	Does amount applied for exceed \$1,000,000? <input type="checkbox"/> <input type="checkbox"/>	
6	Is the policy applied for a second to die life insurance policy? <input type="checkbox"/> <input type="checkbox"/>	

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.
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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.

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 knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Agreement.

SIGNATURES	Signature of Proposed Insured _____ Date _____
	Signature of Other Proposed Insured _____ Date _____
	Signature of Applicant/Owner (if other than Proposed Insured) _____ Date _____
	Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> 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
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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.

Applicant's/Owner's Copy

L8581_1022





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 checkwriting 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

Name: _____

Date: _____

Fit Underwriting Checklist

Complete this form and submit it with **all** of your fully underwritten term and UL applications to receive potential underwriting credits for clients who stay fit and have regular health testing.

Fit Program 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





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

3300 Mutual of Omaha Plaza
 Omaha, Nebraska 68175

**INDEXED UNIVERSAL LIFE PREMIUM ALLOCATION FORM
 (FLEXIBLE PREMIUM ADJUSTABLE LIFE INSURANCE)**

Proposed Insured	Owner (if other than Proposed Insured)
Name (First, Middle Initial, Last)	Name (First, Middle Initial, Last)
	Name (First, Middle Initial, Last)

Premium Allocation

Premium we credit to your account on an Allocation Date will be in the percentages you designate below. Premium we credit to your account on a date other than the Allocation Date will be allocated to the short-term holding account until the next Allocation Date. On a monthly deduction date, account values will be reduced by the pro-rata share of monthly expense charges, cost of insurance charges and any applicable monthly rider costs. The monthly deduction date is the issue date of your policy and each monthly anniversary of the issue date. The Allocation Date is the 10th of each calendar month.

_____ % Fixed Account*

_____ % S&P 500® One-Year 100% Participation^{1*}

_____ % S&P 500® One-Year High Participation^{1*}

_____ % S&P 500® One Year Uncapped^{1*}

_____ % BofA U.S. Agility Index: One-Year Uncapped^{2*}

_____ % **Total (must equal 100%)**

Allocation percentage must be a whole number. Your premium allocations will remain in effect for all premium payments you make, until you change your premium allocations as described in the policy.

Important Disclosures

This is a flexible premium adjustable life insurance policy with index-linked interest crediting options based on financial market indices. This is not an investment vehicle or variable life insurance policy. If you allocate premiums to the index account, the policy values will be affected by the change in the financial market indices. This life insurance policy does not directly participate in any equity, bond, mutual fund, commodities or other securities investments.

¹ The S&P 500® Index is a product of S&P Dow Jones Indices LLC or its affiliates (“SPDJ”) and has been licensed for use by United of Omaha Life Insurance Company. Standard & Poor’s® and S&P® are registered trademarks of Standard & Poor’s Financial Services LLC (“S&P”); Dow Jones® is a registered trademark of Dow Jones Trademark Holdings LLC (“Dow Jones”); and these trademarks have been licensed for use by SPDJI and sublicensed for certain purposes by United of Omaha Life Insurance Company. United of Omaha Life Insurance Company’s index universal life product(s) is not sponsored, endorsed, sold or promoted by SPDJI, Dow Jones, S&P, their respective affiliates, and none of such parties make any representation regarding the advisability of investing in such product(s) nor do they have any liability for any errors, omissions, or interruptions of the S&P 500® Index.

² BofA Securities Inc. and its affiliates (“BofAS”), BofA U.S. Agility Index (the “Index”) and related information, the name “BofAS”, and related trademarks, are intellectual property of BofAS, licensed from BofAS to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company (collectively, the “Licensee”). Neither the Licensee nor any fixed index annuity, indexed universal life insurance product or any other annuity product (collectively, the “Product”) referencing the Index is sponsored, operated, endorsed, sold or promoted by BofAS. Obligations to make payments under any Product are solely the obligation of Licensee pursuant to the term of the contract between Licensee and you, and are not the responsibility of BofAS. BofAS, the Index and related information, the names of BofAS and its affiliates, and related trademarks may not be copied, used, or distributed without BofAS’s prior written approval. The Products have not been passed on as to their legality or suitability, and are not regulated, issued, endorsed, sold, guaranteed, or promoted by BofAS. BofAS’s only relationship to Licensee is the licensing (or sub-licensing) of certain trademarks and trade names and the Index or components thereof and BofAS is not party to any transaction contemplated herein. While volatility controls may result in less fluctuation in rates of return as compared to products or indices without volatility controls, they may also reduce the overall rate of return as compared to products or indices not subject to volatility controls. **BOFAS MAKES NO WARRANTIES AND BEARS NO LIABILITY WITH RESPECT TO THE INDEX, ANY RELATED INFORMATION, THE TRADEMARKS, OR THE PRODUCT(S) (INCLUDING WITHOUT LIMITATION, THEIR QUALITY, ACCURACY, SUITABILITY AND/OR COMPLETENESS).**

* Refer to the Index Interest Crediting Strategies section in the illustration for additional information on Index Interest Crediting Strategies.

Signatures

I authorize United of Omaha Life Insurance Company to allocate premium as selected on this form.

_____ Date _____

Owner Signature

_____ Date _____

Owner Signature



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?



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.

- Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? YES NO
- Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? YES NO
- 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

