



This is only a sample application. It is not a promise to issue coverage.

You **cannot buy** this application **directly** from Mutual of Omaha.

It is **sold only via licensed agencies** such as Choice Mutual.

If you call Mutual of Omaha directly, they will only offer you a policy that has a 2-year waiting period.

To apply, call Choice Mutual
(licensed to sell Mutual of Omaha products)

at 1-800-644-2926.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL OF OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



Application for Individual Life Insurance

PROPOSED INSURED					
Name (First, Middle Initial, Last)		Sex ☐ Male ☐ Female	Height	Weight	Social Security No.
Home Address (Street, City, State, Zip)			State of Birth	Date of Birth	Age
Phone No.	E-mail	Driver's License No.		Driver's License State	
Are you a legal resident of the United States? ☐ Yes ☐ No (If "No", you are not eligible for coverage.)			In the past 12 months, has the Proposed Insured used any form of tobacco or nicotine replacement therapy? ☐ Yes ☐ No		
OWNER (Complete only if Owner/Applicant is different from Proposed Insured)					
Name of Policyowner (First, Middle Initial, Last)			Relationship to Proposed Insured		
Policyowner Address (Street, City, State, Zip)			Phone No.	Social Security No.	
Sex ☐ Male ☐ Female	Date of Birth	Age	E-mail	Citizenship Country	
UNDERWRITING					
Part One IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN PART ONE, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.					
1. Is the Proposed Insured currently: (a) bedridden or confined to any hospital, nursing home, long-term care facility or skilled nursing facility; or receiving or been advised to receive care in a nursing home, hospice care, or home health care? (b) requiring assistance with activities of daily living such as taking medications, bathing, dressing, eating, toileting, getting in and out of a chair or bed, or control of bowel or bladder problems? (c) requiring any of the following (other than for fractures, bone or joint surgery, including replacement): wheelchair, electric scooter, or oxygen equipment to assist breathing (excluding use for sleep apnea)?					☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
2. Has the Proposed Insured ever been: (a) diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? (b) diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Quadriplegia, Paraplegia, Down's Syndrome, mental incapacity, congestive heart failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type? (c) diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed with End Stage Renal Disease or requiring dialysis? (d) advised to receive or have received an organ or bone marrow transplant? (e) diagnosed by a physician or health care provider as having a terminal medical condition that is expected to result in death within the next twelve 12 months?					☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
3. In the past 12 months, has the Proposed Insured been: (a) advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known? (b) diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind? . .					☐ Yes ☐ No ☐ Yes ☐ No
4. In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for any form of cancer (except basal or squamous cell skin cancer)?					☐ Yes ☐ No

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PLEASE SUBMIT ALL PAGES

Part Two IF THE PROPOSED INSURED ANSWERS “YES” TO ANY QUESTION IN PART TWO, THAT PERSON IS ELIGIBLE ONLY FOR THE GRADED BENEFIT PRODUCT.

5. Has the Proposed Insured ever (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for: (a) Diabetes before age 50 or diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)? (b) Hepatitis C? (c) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
6. In the past 4 years, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for: (a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)? ... (b) Chronic Kidney Disease, Systemic Lupus or Scleroderma? (c) Bipolar Depression, Schizophrenia, Parkinson’s Disease or Multiple Sclerosis?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
7. In the past 2 years, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for: (a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement? (b) Stroke or Transient Ischemic Attack (TIA)?	☐ Yes ☐ No ☐ Yes ☐ No
8. In the past 2 years, has the Proposed Insured: (a) been convicted of or currently awaiting trial for a felony? (b) been treated for or advised to have treatment for alcohol or drug abuse or convicted more than once of reckless driving or driving under the influence of drugs or alcohol? (c) used unlawful drugs in any form or abused or misused prescription drugs?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
9. In the past 2 years, has the Proposed Insured been hospitalized by a physician or health care provider for any mental or nervous disorder?	☐ Yes ☐ No
10. In the past 12 months, has the Proposed Insured consulted a physician for chronic cough, <u>unexplained</u> weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding?	☐ Yes ☐ No

NOTE: If the Proposed Insured answers all above questions “No”, that person is eligible for the Level Benefit Product.

OPTIONAL COMMENTS (Not Required) - Provide any additional information available.

Question Number	Details to Underwriting Questions (Diagnosis, Dates, Durations, Medications, Dosages)

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PLAN INFORMATION

Plan:

☐ Level Benefit Product ☐ Graded Benefit Product

Amount Applied For \$ _____

Rider: (Only if selecting Level Benefit Product)

☐ Accidental Death Rider

Payment Mode:

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (Automated Bank Account Withdrawal)

Modal Premium \$ _____ Collected Premium \$ _____

BENEFICIARY (If more space is needed, list on a separate sheet)

Primary Beneficiary

Relationship to Insured

Date of Birth

Contingent Beneficiary

Relationship to Insured

Date of Birth

OTHER COVERAGE INFORMATION

1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No

2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with the company or any other company? ☐ Yes ☐ No
If "Yes" to questions #1 or #2, please give details below. If more space is needed, list on a separate sheet.

Company

Proposed Insured

Face Amount

To be Replaced or Converted?

☐ Yes ☐ No☐ Yes ☐ No**AUTHORIZATION and AGREEMENT**

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

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

- CONTINUED ON NEXT PAGE -

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.

If applying for the Graded Benefit Product: I understand that a reduced death benefit amount is payable during the first two policy years if death results from sickness or other natural causes. The full face amount is payable during the first two policy years if death results from an accident.

Signed at: _____

City

State

Signature of Proposed Insured

Date: _____

Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)

Date: _____

Producer Statement:

By signing below, I/we, the Producer(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

1. 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
2. Do you, the Producer(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy or annuity contract in force with the company or any other company? ☐ Yes ☐ No
3. Has the Proposed Insured informed you, the Producer(s), that he/she has any pending or existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No
(If the above questions are answered "Yes," fulfill all state and company requirements.)
4. Are you related to the Proposed Insured or Owner? ☐ Yes ☐ No

If "Yes," state relationship _____

5. How long have you known the Proposed Insured? _____

6. How long have you known the Proposed Owner? _____

7. Previous residence of Proposed Insured for the past five years.

Street Address	City	State	Zip Code

8. I/We conducted said interview in person ☐ Yes ☐ No

If "No," please explain _____

Signature of Producer #1 _____ Producer E-mail _____ Production Number _____ Date _____

Signature of Producer #2 _____ Producer E-mail _____ Production Number _____ Date _____

Print Producer #1 Name _____ Print Producer #2 Name _____ Agency Name _____

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Producer Report

- 1 Was a Personal Health Interview (PHI) conducted by Apptical Corporation as a part of the application process?.....☐ Yes ☐ No

If Yes, please provide the PHI number_____

- 2 List any additional information or comments below:

SAMPLE
FROM CHOICE MUTUAL

L8532_0615



UNITED OF OMAHA LIFE INSURANCE COMPANY

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



PAYMENT AUTHORIZATION FORM

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

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

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

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

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

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

PAYMENT INFORMATION FOR ONGOING PAYMENTS- AUTOMATIC BANK ACCOUNT DEDUCTION

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

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

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

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

PAYOR INFORMATION

Name of payor as shown on bank account: _____

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

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

PAYOR ACCOUNT INFORMATION

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

2. Name of Financial Institution: _____

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

Bank Routing Number: _____ Bank Account Number: _____

(Do not use Debit/Credit Card numbers)

Memo _____	Signed By: _____
1:123456789:1 12345678 11 1234 11	

Bank Routing
Number

Bank Account
Number

Check Number (if shown at bottom, may
be shown before or after the account #)

PAYOR AUTHORIZATION

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

Date _____ X _____

Mo./Day/Yr.

Payor Authorized Signature as Shown on Account

CONDITIONAL RECEIPT ("RECEIPT")

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

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

DATE OF RECEIPT: _____

BENEFIT	For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) \$40,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed \$40,000.
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CONDITIONS	Conditions under which a benefit may be payable under this Receipt prior to policy delivery: 1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and 2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and 3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and 4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United. If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.
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END DATE	This Receipt and any coverage provided hereunder will END on the earliest of the following dates: 1 60 days from the date of this Receipt; 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 the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or 4 The date the Applicant/Owner withdraws the application for insurance.
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SIGNATURES	This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application. I/We have read and received a copy of this Receipt and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt. <table><tr><td>Signature of Proposed Insured</td><td>Date</td></tr><tr><td>Signature of Other Proposed Insured</td><td>Date</td></tr><tr><td>Signature of Applicant/Owner (if other than Proposed Insured)</td><td>Date</td></tr></table> Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized \$ _____ I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner. <table><tr><td>Signature of Producer</td><td>Date</td></tr><tr><td>Signature of Producer</td><td>Date</td></tr></table> 	Signature of Proposed Insured	Date	Signature of Other Proposed Insured	Date	Signature of Applicant/Owner (if other than Proposed Insured)	Date	Signature of Producer	Date	Signature of Producer	Date
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Signature of Producer	Date										
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UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefit received under the rider may be taxable. Receipt of the accelerated death 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 the benefit.

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness or Nursing Home Confinement 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 or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

While the rider is in force and the insured has a terminal illness or is under nursing home confinement, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. Nursing home confinement means that the insured has been confined to a nursing home for at least 90 consecutive days and is expected to remain confined for the remainder of his or her life. A physician must certify that the insured has a terminal illness or is under nursing home confinement.

The amount available for the accelerated death benefit is your policy's death benefit. You may receive the accelerated death benefit only once.

For a terminal illness, we will reduce the accelerated death benefit by 6%.

For nursing home confinement, we will reduce the accelerated death benefit by the nursing home confinement factor. The nursing home confinement factor varies by policy year as shown in the rider. We will also reduce the accelerated death benefit by a \$100 charge and by the amount of any loans and unpaid premiums.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The rider will terminate when the accelerated death benefit is paid.

NOTE: If the policy is issued as a graded death benefit, the accelerated death benefit is not available.

Acknowledgment

I acknowledge receipt of this disclosure form.

Applicant/Owner Signature

Date

I have provided this disclosure form to the applicant/owner.

Producer Signature

Date



AUTHORIZATION FOR RELEASE OF INFORMATION TO MY INSURANCE AGENT, AGENCY AND/OR AUTHORIZED THIRD PARTY VENDOR

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

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

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

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

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

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

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

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

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