This is only a sample application. It is not a promise to issue coverage.
# Application for Children's Whole Life Insurance

## Section A: Owner/Applicant
- **Owner/Applicant Name (First Name, Initial, Last Name)**
- **Social Security No.**
- **Male**
- **Female**
- **Home Address (Street, City, State, ZIP)**
- **Date of Birth (Month, Day, Year)**
- **Phone Number**
- **E-mail Address**
- **Are you a legal permanent resident of the United States?**

## Section B: Beneficiary
- **Primary Beneficiary**
- **% of Proceeds**
- **Relationship to Proposed Insured**
- **Date of Birth**
- **Contingent Beneficiary**
- **% of Proceeds**
- **Relationship to Proposed Insured**
- **Date of Birth**

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

## Section C: Secondary Addressee (Optional) - This Person Will Receive Copies of Overdue Premium and Lapse Notices.
- **Name (First Name, Initial, Last Name)**
- **Phone Number**
- **Address (Street, City, State, ZIP)**

## Section D: Proposed Insured(s) Information (List Children Ages 14 Days to 17 Years)

<table>
<thead>
<tr>
<th>First Name, Middle Initial, Last Name</th>
<th>Date of Birth</th>
<th>Sex M/F</th>
<th>Coverage Amount</th>
<th>Premium</th>
<th>Owner Relationship to Insured</th>
<th>Legal Permanent Resident of the United States?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

**Note:** Use additional sheet if necessary.

## Section E: Other Coverage and Replacement Information

Do any of the Proposed Insureds:
1. have any existing life insurance or annuity contracts with the company or any other company?  
2. intend for this insurance to replace or change any existing life insurance or annuity contract with the company or any other company?

If "Yes" to either question, give details below:

<table>
<thead>
<tr>
<th>Proposed Insured's Name</th>
<th>Company</th>
<th>Policy Number</th>
<th>Will this insurance be replaced?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

The producer shall comply with any additional state and/or company replacement requirements.
SECTION F  HEALTH INFORMATION

Have any of the Proposed Insureds been diagnosed or treated by a licensed member of the medical profession for:
(a) a heart or circulatory system disease, birth defect, or mental or developmental disorder including autism and Down’s Syndrome?  Yes  No
(b) any other chronic medical condition which has required care within the past 3 years?  Yes  No

NOTE: Provide details for “Yes” answers. Please include Proposed Insured’s name and illness or condition. (Use additional sheet if necessary.)

<table>
<thead>
<tr>
<th>Proposed Insured’s Name</th>
<th>Details of Illness or Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION G  PREMIUM AND BILLING INFORMATION

1. Amount collected $ ______________  Modal Premium for Proposed Insured(s) $ ______________

2. Mode of Payment:  □ Monthly Bank Service Plan

SECTION H  AGREEMENT

I represent that my above answers are true and complete to the best of my knowledge and belief. I also understand that this coverage will not be in force until this application is completed in full and approved by United of Omaha Life Insurance Company, and the initial premium is received during the lifetime of the Proposed Insured(s).

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.

I have read and understand this Agreement Section and I approve all the answers as recorded in this application.

Signed at: ____________________________________________  Today’s Date: ______________
City                                      State   Month   Day   Year

Signature of Owner/Applicant
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 by 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: ________________

(Don’t use Debit/Credit Card numbers)

Memo: ____________________________________________________________

Signed By: ________________________________________________________

1: 12345678911  1234567811*  1234 11*

Payor Authorized Signature as Shown on 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