WASHINGTON D.C. - Application for Life Insurance **Living Promise Product** - One Base Policy per Application



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

Checklist for Submitting a Complete Application

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

FAX: 1-402-997-1800

	Please choose the precise Plan, Rider, and amount of insurance applied for					
	Level Benefit Product: • Accelerated Death Benefit Rider • Accidental Death Benefit Rider (optional)	☐ Graded Benefit Product (if available): • No Riders Available				
Ap	plication Submission Guidelines					
	Attach a cover letter or additional information as needed.					
	Always submit the Producer Report page.					
	Leave all applicable forms and Life Buyer's Guide with the Proposed Insured.					
	All changes should be initialed and dated by the Applicant/Owner.					
	☐ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.					
lm	Important Forms					
	Replacement Notice - if applicable, the client must sign and	retain a copy for their records				
	Payment Authorization - Complete this form if applicable					
	Conditional Receipt - Complete <u>ONLY</u> if you accepted a check or electronic transaction authorization at time of application for the initial premium. DO NOT complete the Conditional Receipt if initial payment won't be collected until issue.					
	Accelerated Benefit Rider Disclosure - The client must sign	the Accelerated Benefit Rider Disclosure Form				
	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 Forms and Buyer's Guide:

• Buyer's Guide: For all life products, the shopping guide for insurance is to be given to the consumer at point of sale.





INDIVIDUAL LIFE INSURANCE APPLICATION

PF	ROPOSED INSUR	RED												
Fir	st Name		MI	Last N	Name		Suffi	ix	□ Male	Height	We	ight	Socia	al Security No.
									☐ Female					
Но	me Address Street				Apt/Ste#	City			State	Zip		Sta of I	ite Birth	Date of Birth
Ph	one No.			E-mail	•	•	Drive	er's	License N	0.	D	river's	s Licen	se State
Are you a U.S. citizen or legal permanent resident of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months, has the Proposition of the United States? Yes No In the past 12 months No					duct containing									
0	WNER (Complete	only if	Own	er/Applic	ant is diff	erent from Pr	roposed	Ins	sured)					
Fir	st Name		MI	Last	Name				Suffix	Relatio	onship	to Pr	opose	d Insured
Str	eet Address			Apt/Ste#	City		State	Zi	ip	Phone N	0.		Socia	l Security No.
	Male □ Female	Date o	of Bir	rth	E-ma	ail					Citize	enship	Cour	ntry
U	NDERWRITING													
Pa	rt One IF THE PRO ELIGIBLE FO					"YES" TO QI		NS	2-5 IN PA	RT ONE,	THAT	PER	SON IS	NOT
1.	Has the Proposed positive for Humar												AIDS)?	? ☐ Yes ☐ No
 2. 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 by a member of the medical profession 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): 							☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No							
3.	 3. Has the Proposed Insured ever (i) been diagnosed with, (ii) received treatment for, or (iii) been advised by a member of the medical profession to seek treatment for: (a) Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Hydrocephalus, Muscular Dystrophy, Quadriplegia, Paraplegia, Down Syndrome, Intellectual Developmental Disorder, Congestive Heart Failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type? (b) insulin shock, diabetic coma, amputation due to diabetic complications, End Stage Renal Disease or requiring dialysis? (c) an organ or bone marrow transplant? 						☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No							
4. In the past 12 months, has the Proposed Insured been: (a) advised by a member of the medical profession 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?						Yes 🗆 No								
5.	In the past 2 years of the medical protocancer)?	fession	to r	eceive tre	atment fo	r any form of	cancer	(ex	cept basal	l or squan	nous c	ell sk	in	☐ Yes ☐ No

UNDERWRITING, Continued						
		URED ANSWERS "YES" TO ANY ED BENEFIT PRODUCT.	QUESTION IN PA	ART TWO, THAT PERSON IS	S ELIGIBLE	
member of the (a) Diabetes I (b) Diabetes a Neuropath (c) Hepatitis I (d) Chronic L	e medical profes before age 45? at any age with co ny (nerve), Periph C?ung Disease, inc	(i) been diagnosed with, (ii) recession to seek treatment for: omplications or history of Retinopateral Vascular Disease (PVD or PAL luding Chronic Obstructive Pulmos?	thy (eye), Nephro D), Coronary Arter Donary Disease (C	pathy (kidney), ry Disease (CAD) or Stroke? . OPD), Chronic Bronchitis,		
advised by a l (a) Cancer, Le (b) Chronic K	 7. In the past 4 years, has the Proposed Insured: (i) been diagnosed with, (ii) received treatment for, or (iii) been advised by a member of the medical profession to seek treatment for: (a) Cancer, Leukemia, or any other internal cancer or Melanoma (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					
advised by a r (a) Coronary irregular h	8. In the past 2 years, has the Proposed Insured: (i) been diagnosed with, (ii) received treatment for, or (iii) been advised by a member of the medical profession to seek treatment for: (a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, Pacemaker or Valvular Heart Disease with surgical repair or replacement?					
(a) been con (b) been treat convicted	9. In the past 2 years, has the Proposed Insured: (a) been convicted of or currently awaiting trial for a felony?					
10. In the past 2 any mental or	years , has the Pr nervous disorde	oposed Insured been hospitalizeder?	by a member of	the medical profession for	☐ Yes ☐ No	
profession for gastrointestir	r chronic cough, in al bleeding?	e Proposed Insured been diagnose <u>unexplained</u> weight loss greater t	han 10 pounds, fa	atigue or unexplained	☐Yes ☐ No	
		wers all above questions "No", that	·			
Question Number	OMINIEN 13 (I	Not Required) - Provide any ac Details to Un (Diagnosis, Dates, Dura	derwriting Ques	tions		
PLAN INFORM	MATION					
	Plan: ☐ Level Benefit Product ☐ Graded Benefit Product ☐ Accidental Death Rider ☐ Accidental Death Rider					
PREMIUM INF			1			
Premium Method		☐ Direct Bill ☐ Bank Dr ☐ Other(Please Explain)	aft (Complete Pay	yment Authorization Form)		
Frequency of Mo	dal Premium	☐ Monthly (Bank Draft Only)	☐ Annual	☐ Semi-Annual ☐ (Quarterly	
Modal Premium \$	\$				-	
Name & Address of Payor (if other than Proposed Insured/Owner)						
Relationship of Payor (if other than Proposed Insured/Owner)						

ICC231 681A

	BENEFICIARY (If more space is needed, list on a separate sheet)					
Primary Beneficiary First Name N	II Last Name	2	Suffix	Rela	ationship to Insured	Date of Birth
Contingent Beneficiary First Name M	I Last Nam	е	Suffix	Rela	ationship to Insured	Date of Birth
OTHER COVERAGE INFORI	MATION					•
1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company?						
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?						
Company		Proposed Insu	red		Face Amount	To be Replaced or Converted?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
AUTHORIZATION and AGE	REEMENT					
information regarding communicate condition, prescription drug recommunicate condition, prescription drug recommunicate contest any issues of incomplet. United of Omaha to disclose information of request, to another member compile the person or entity to whom in regulations, the information may be valid for 24 months from the date state where the policy is delivered applying for will not be issued. In is limited to the extent that United to contest the issuance of the policy accorded to the information of the policy and the issue date of the policy will be the You must immediately notify United to change any statement or answer to be in effect if the Proposed Insure or change any receipt or policy processes and subject to pell applying for the Graded Benefit years if death results from an accident. Signed at: City Signature of Proposed Insured	ds, drug or a pmaha"). The se, incorrect mation to Morany with who formation is peredisclosed signed. This do from the dof Omaha log or a claim mation above application althat no insue of the first premited of Omaha log only questing dies or is covision or again knowingly phalties under the formation or again who will be first premited of Omaha log only questing dies or is covision or again knowingly phalties under the formation of the first premited of the	Icohol use, driving received information will be used or misrepresented in IIB. I understand that nom I apply for life or disclosed is not a head without the protect of time limit complies for delivery. I may refusive authorization at an has taken action in required and any issued policy, arance shall take effection in the policy, even the if there has been a complete and the policy, even the if there has been a complete and any issued policy, arance shall take effection in the application of the policy, even the if there has been a complete and in the application of the policy is a false staten and complete to issue any policy resents a false staten are state law.	cord or i used to deformation my information health in alth care tion of the with the se to signly time to the contract of Contract of Contract of Contract of Contract of the insection of the i	nsuradeter on	ance claims information of mine my eligibility for a this application that man ion received by MIB mance or to whom I may wider or health plan sulderal privacy regulation is authorization but if I written notice to United a authorization or the lactopy of this authorization or the lactopy of the lac	on, to United of Omaha Life insurance or to resolve may arise. I also authorize hay be disclosed, upon y submit a claim for benefits bject to federal privacy ons. This authorization is d by applicable law in the refuse, the insurance I am of Omaha. This revocation aw allows United of Omahation. belief. Any incorrect or therwise provided under requirements have been I Insured's lifetime. The eafterive until a later date. ealth or habits that will lied. No policy of any kind will lied. No producer can waive a may be guilty of a
Date:						
Signature of Applicant/Owner/Tr	Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)					

ICC23L681A

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

PRODUCER STATEMENT

insurance or annuity contract	ormed you, the Producer(s), that he/s ts with the company or any other com nswered "Yes," fulfill all state and co	npany?				
	ve any reason to believe the policy ap contract in force with the company or					
B. Did you, the Producer(s), give the Proposed Insured the MIB, LLC Pre-Notice, the Notice of Information Practices (if applicable) and the Life Insurance Buyer's Guide?						
If "No," please explain						
	interview with the Proposed Insured, e Proposed Insured(s) completely an					
5. I/We conducted said interv	5. I/We conducted said interview in person					
If "No," please explain _						
6. (a) Are you the Proposed In	sured or Owner?		□ Yes □ No			
(b) Are you related to the Pr	roposed Insured or Owner?					
If "Yes," state relationsh	ip					
7. How long have you known th	ne Proposed Insured?					
8. How long have you known t	he Proposed Owner?					
Print Producer #1 Name	Producer E-mail	Production Number	Agency Name			
Signature of Producer #1	Date					
Print Producer #2 Name	Producer E-mail	Production Number	Agency Name			
Signature of Producer #2	 Date					



Producer Report

1	Was a Personal Health Interview (PHI) conducted by Apptical Corporation as a part of the application process	s? Yes	□No
	If Yes, please provide the PHI number		
2	List any additional information or comments below:		



United of Omaha Life Insurance Company Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

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 wi	ithdrawal for a premium payment.					
PAYMENT INFORMATION FOR THE FIRST PAYMENT- CAN BE D	OFFERENT THAN THE ONGOING PAYMENTS					
initial payment will be deducted on the date the policy is issued ☐ Check collected and mailed to Mutual of Omaha	(Please Note: If the policy issue is after the date selected, the					
	Payment Information For Ongoing Payments - Automatic Bank Account Deduction					
Ongoing Automatic Monthly Premium Payments (Once a Month Choose the day payments will be deducted every month (1st through the 28th or Last Day of every month) -OR- Choose the week and weekday that payments will be ded (For example, 3rd Wednesday of every month) Week (1st, 2nd, 3rd, 4th, Last))- Select only one option from your bank account: ducted every month from your bank account: eekday (Mon, Tue, Wed, Thu, Fri)					
Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). Ongoing deductions will begin once the policy is issued. If the scheduled deduction date lands on a weekend or holiday, the payment will process on the following business day. PAYOR INFORMATION						
Name of payor as shown on bank account: If premium is NOT paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation may be required) Employer Business owned by Proposed Insured/Insured or spouse Other Power of Attorney or legal guardian						
PAYOR ACCOUNT INFORMATION						
Memo Signed By I:123456789: 12345678 * 1234 Bank Routing Number Bank Account Number Check Number be shown be	Bank Account Number:(Do not use Debit/Credit Card numbers)					
PAYOR AUTHORIZATION						
I authorize United of Omaha Life Insurance Company to initiate any account. I understand the amounts may vary as premium shortages adjustments. This authorization will be effective until I give you at leverbally, United of Omaha Life Insurance Company may require writt DateX						
,						

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.

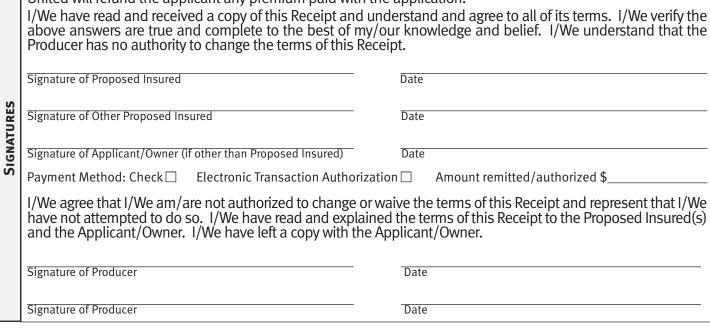
I understand that I will receive a copy of the authorization.

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



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".						
	Dat	TE 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) \$50,000 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 \$50,000.					
	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. 					
	END DATE	 This Receipt and any coverage provided hereunder will END on the earliest of the following dates: 60 days from the date of this Receipt; or The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or 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 The date the Applicant/Owner withdraws the application for insurance. 					
		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. Signature of Proposed Insured Date					







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	



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).



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:

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) \$50,000 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 \$50,000.

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
- 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.

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

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

The date the Applicant/Owner withdraws the application for insurance.

	This Receipt does not limit United in applying its underwriting limit or waive any rights under any life insurance policy iss United will refund the applicant any premium paid with the all/We have read and received a copy of this Receipt and under above answers are true and complete to the best of my/ou Producer has no authority to change the terms of this Receipt	ued. If United rejects or declines the application, application. Erstand and agree to all of its terms. I/We verify the r knowledge and belief. I/We understand that the				
	Signature of Proposed Insured	Date				
IGNATURES	Signature of Other Proposed Insured	Date				
GNAT	Signature of Applicant/Owner (if other than Proposed Insured)	Date				
Sı	Payment Method: Check Electronic Transaction Authorization Amount remitted/authorized \$					
	I/We agree that I/We am/are not authorized to change or wai have not attempted to do so. I/We have read and explained and the Applicant/Owner. I/We have left a copy with the App	the terms of this Receipt to the Proposed Insured(s)				
	Signature of Producer	Date				
	Signature of Producer	Date				



APPLICANT COPY T047LNA13A 50

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.

L X	Šo X		∠ X	
Sig	gnature of Applicant A	Date	Signature of Applicant B	Date



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.

Applicant's/Owner's Copy

L7941_1022





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

Acknowledgment

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.

I acknowledge receipt of this disclosure form. Applicant/Owner Signature I have provided this disclosure form to the applicant/owner. Producer Signature Date

