VERMONT – 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:**	❑ **Graded Benefit Product (if available):**
• Accelerated Death Benefit Rider • Accidental Death Benefit Rider **(optional)**	• No Riders Available

Application 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.

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 ONLY 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.

Mutual of Omaha

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

PROPOSED INSURED

First Name	MI	Last Name	Suffix	☐ Male ☐ Female	Height	Weight	Social Security No.

Home Address Street	Apt/Ste#	City	State	Zip	State of Birth	Date of Birth

Phone No.	E-mail	Driver's License No.	Driver's License State

Are you a U.S. citizen or legal permanent 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 tobacco or any product containing nicotine ?..... ☐ **Yes** ☐ **No**

OWNER (Complete only if Owner/Applicant is different from Proposed Insured)

First Name	MI	Last Name	Suffix	Relationship to Proposed Insured

Street Address	Apt/Ste#	City	State	Zip	Phone No.	Social Security No.

☐ Male ☐ Female	Date of Birth	E-mail	Citizenship Country

UNDERWRITING

Part One IF THE PROPOSED INSURED ANSWERS "YES" TO QUESTIONS 2-5 IN PART ONE, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.

1. Has the Proposed Insured **ever** been diagnosed as having Human Immunodeficiency Virus (HIV) or been treated for HIV by a physician or medical professional? ☐ **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 to receive care in a nursing home, hospice care, or home health care? ☐ **Yes** ☐ **No**
(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? ☐ **Yes** ☐ **No**
(c) requiring any of the following (other than for fractures, bone or joint surgery, including replacement): wheelchair, electric scooter, oxygen equipment to assist breathing (excluding use for sleep apnea) or defibrillator? ☐ **Yes** ☐ **No**

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? ☐ **Yes** ☐ **No**
(b) insulin shock, diabetic coma, amputation due to diabetic complications, End Stage Renal Disease or requiring dialysis? ☐ **Yes** ☐ **No**
(c) an organ or bone marrow transplant? ☐ **Yes** ☐ **No**
(d) a terminal medical condition that is expected to result in death within the next twelve (12) months? ☐ **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), treatment, hospitalization, or other procedure which has not been done or for which results are not known? ☐ **Yes** ☐ **No**
(b) diagnosed by a member of the medical profession as having heart disease or heart surgery of any kind? ☐ **Yes** ☐ **No**

5. **In the past 2 years**, has the Proposed Insured been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for any form of cancer (except basal or squamous cell skin cancer)? ☐ **Yes** ☐ **No**

T217LVT23A

UNDERWRITING, Continued

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

6. 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) Diabetes before age 45?	☐ Yes ☐ No
(b) Diabetes at any age with complications or history of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve), Peripheral Vascular Disease (PVD or PAD), Coronary Artery Disease (CAD) or Stroke?	☐ Yes ☐ No
(c) Hepatitis C?	☐ Yes ☐ No
(d) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?	☐ Yes ☐ No
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)?	☐ Yes ☐ No
(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?	☐ Yes ☐ No
(c) Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis?	☐ Yes ☐ No
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?	☐ Yes ☐ No
(b) Stroke or Transient Ischemic Attack (TIA)?	☐ Yes ☐ No
9. In the past 2 years, has the Proposed Insured:	
(a) been convicted of or currently awaiting trial for a felony?	☐ Yes ☐ No
(b) been treated for or advised by a member of the medical profession to have treatment for alcohol or drug abuse, convicted of driving under the influence of drugs or alcohol or convicted more than once of reckless driving?	☐ Yes ☐ No
(c) used unlawful drugs in any form (other than marijuana) or abused or misused prescription drugs?	☐ Yes ☐ No
10. In the past 2 years, has the Proposed Insured been hospitalized by a member of the medical profession for any mental or nervous disorder?	☐ Yes ☐ No
11. In the past 12 months, has the Proposed Insured consulted a member of the medical profession for chronic cough, unexplained 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)

PLAN INFORMATION

Plan:
☐ Level Benefit Product ☐ Graded Benefit Product

Amount Applied For $ _____

Rider: (Only if selecting Level Benefit Product)
☐ Accidental Death Rider

PREMIUM INFORMATION

Premium Method	☐ Direct Bill ☐ Bank Draft *(Complete Payment Authorization Form)* ☐ Other(Please Explain)_____
Frequency of Modal Premium	☐ Monthly (*Bank Draft Only*) ☐ Annual ☐ Semi-Annual ☐ Quarterly

Modal Premium $_____ Collected Premium $_____

Name & Address of Payor (if other than Proposed Insured/Owner)_____

Relationship of Payor (if other than Proposed Insured/Owner)_____

T217LVT23A

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

Primary Beneficiary First Name	MI	Last Name	Suffix	Relationship to Insured	Date of Birth
Contingent Beneficiary First Name	**MI**	**Last Name**	**Suffix**	**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**
			☐ **Yes** ☐ **No**

AUTHORIZATION and AGREEMENT

Authorization: I authorize any medical provider, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical care facility, MIB, LLC (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 information regarding communicable or infectious conditions, 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"). **NOTE: This authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies. The proposed insured/ applicant IS NOT authorizing the company to forward the results from any new test requested by the company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.** 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 United of Omaha. 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: 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 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.

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

_____ Date: _____
Signature of Proposed Insured

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

T217LVT23A

Mutual of Omaha

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

Producer Statement

1. 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.)

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. 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? ☐ **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**

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

If "No," please explain _____

6. **(a)** Are you the Proposed Insured or Owner? ☐ **Yes** ☐ **No**

(b) Are you related to the Proposed Insured or Owner? ☐ **Yes** ☐ **No**

If "Yes," state relationship _____

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

8. How long have you known the 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 _____

T246LNA23A

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:

_____

_____

_____

_____

_____

_____

_____

United of Omaha Life Insurance Company

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

PAYMENT AUTHORIZATION FORM

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

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

Payment Information For The First Payment- Can Be Different Than The Ongoing Payments

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

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

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

Payment Information For Ongoing Payments- Automatic Bank Account Deduction

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

- ☐ Choose the day payments will be deducted every month from your bank account:
  (**1st through the 28th** or **Last Day** of every month) _____

-OR-

- ☐ Choose the week and weekday that payments will be deducted every month from your bank account:
  (For example, 3rd Wednesday of every month)
  Week (1st, 2nd, 3rd, 4th, Last) _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____

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

Payor Information

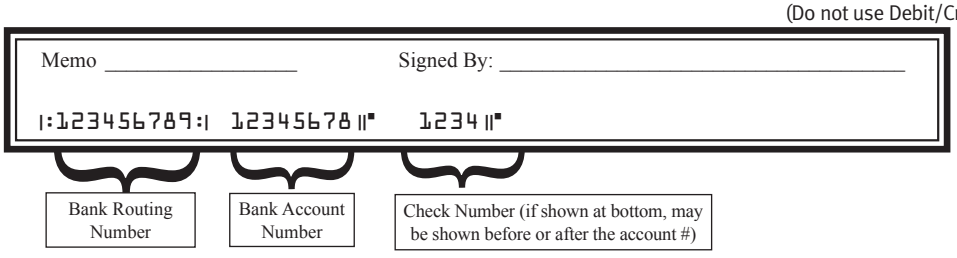
Name of payor as shown on bank account: _____

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

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

Payor Account Information

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



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

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

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

M28704

Company's Copy

Mutual of Omaha

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

Third Party Notice

You have the right to designate a person, in addition to yourself, to receive notice that your premium is past due and has not been paid. This extra notice will be sent at least 21 days prior to the effective date of cancellation of your policy or certificate only if you are age 64 or older. This notice will state the amount of premium, the date by when the premium must be paid and the date on which coverage terminates. You can designate this additional person to receive notice of nonpayment now or at a later time, provided the policy is in force, and you give us written notice containing the additional person's name and address.

You have the right to change this third-party designation at any time; however, you must submit the change in writing to the address below.

Please Complete Either Section 1 or Section 2 And Return To Us.

Section 1

I wish to designate an additional person to receive notice of nonpayment of premium.

Policyowner/Certificateholder: _____

Policy Number: _____

Date: _____

Third Party:_____
(Please print name of other person to receive notice of nonpayment

Third Party Address: _____
(Street Address) (City) (State) (Zip)

Signature of Policyowner/Certificateholder

_____

Date _____

Section 2

I do not wish to designate an additional person to receive notice of nonpayment of premium.

Signature of Policyowner/Certificateholder

_____

Date _____

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) $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:
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.

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.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

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.

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date

Mutual of Omaha

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

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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:_____

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:
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.

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.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

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.

_____ _____
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

M28704

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

Mutual of Omaha

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

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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