UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

Home Office Use Only.
Code

MUTUAL of OMAHA

Application for 1[Marketing Name]
Individual Life Insurance

Please Reply By

2 [General Tracking Codes]

PROPOSED INSURED

Name _____
First Name Middle Initial Last Name

Sex ☐ Male ☐ Female

Address _____
Street City State ZIP Code

Social Security No._____-_____-_____

E-mail Address _____ _____

Phone (_____)_____-_____

Date of Birth _____/_____/_____ Height/Weight_____/_____

Birth State_____

Are you a legal resident of the United States? (If "No," you are not eligible for coverage.) ☐ Yes ☐ No

In the past 12 months have you used any form of tobacco? ☐ Yes ☐ No

3 [Variable Benefit Options]

[☐] [Description]
[Select benefit amount] [(Please check one)] [☐] [$00,000] [☐] [$00,000] [☐] [$00,000]

4 [Optional Coverage]

Does the Proposed Insured have any existing life insurance or annuity contracts with the company or any other company? ☐ Yes ☐ No
Will this insurance replace or change any existing life insurance or annuity contract with the company or any other company? ☐ Yes ☐ No

If "Yes" to either question, give details: Company(ies)_____ Policy No.(s) _____

BENEFICIARY(IES): (Please Print)

5

Name_____
First Name Middle Initial Last Name

[Address_____
Street City State ZIP Code

[Phone (_____)_____-_____] Date of Birth ____/_____/_____

[Social Security No._____-_____-_____]

Relationship to Insured_____ % of Proceeds _____

Name_____
First Name Middle Initial Last Name

[Address_____
Street City State ZIP Code

[Phone (_____)_____-_____]Date of Birth ____/_____/_____

[Social Security No._____-_____-_____]

Relationship to Insured_____ % of Proceeds _____

Note: If proceeds % is not specified, share will be divided equally among beneficiaries named.

PAYMENT INFORMATION

6A, 6B,6C [Variable Payment Methods]

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

		YES	NO
1.	Have you **ever** been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
2.	**In the past 5 years**, have you:		
a)	used or been convicted of possession of unlawful drugs or used prescription drugs in any form other than as prescribed?	☐	☐
b)	been convicted of or currently awaiting trial for a felony, convicted of driving under the influence of drugs or alcohol or convicted of 4 or more moving violations?	☐	☐
3.	Are you currently bedridden or confined to any hospital, nursing home, or other medical facility?	☐	☐
4.	Have you **ever** been declined for life insurance coverage?	☐	☐
5.	**In the past 5 years**, have you ever received treatment for, or been diagnosed by a member of the medical profession as having:		
a)	Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease with surgical Repair or Replacement, Cardiomyopathy, Congestive Heart Failure, Congenital Heart Disease, Stroke, Transient Ischemic Attack (TIA)/mini-stroke, abnormal heart rhythm, or Cerebral, Aortic or Thoracic Aneurysm?	☐	☐
b)	Kidney Disease, Liver Disease, Leukemia, Melanoma or other Cancer (excluding basal cell skin cancer), Chronic Bronchitis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Systemic Lupus, an Organ Transplant or Alcoholism or used alcohol to a degree that required treatment?	☐	☐
c)	Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Sickle Cell Anemia, Lou Gehrig's Disease (ALS), Muscular Dystrophy, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down's Syndrome, Autism, or any other disease of the central nervous system?	☐	☐
d)	Diabetes with onset before age 50 or with vascular or renal complications?	☐	☐

PLEASE READ & SIGN

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 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: I represent that any and all answers to the questions in this application are true and complete to the best of my knowledge and belief and will be used by United of Omaha to determine my insurability. I also understand that coverage will not be in force until this application is completed in full and approved by United of Omaha, all outstanding application requirements have been received, my initial premium has been received and a policy has been issued, all during my lifetime. Applicant agrees that this application does not provide temporary or interim insurance prior to policy issue. Coverage under the policy, if issued, will be effective on the policy issue date shown in the policy. The initial premium will provide coverage from the policy issue date until the date the next premium is due.

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.

X Proposed Insured Signature_____ **Date** _____