UNITED OF OMAHA LIFE INSURANCE COMPANY

Mutual of Omaha Plaza
Omaha, Nebraska 68175
LIFE INSURANCE APPLICATION

Administration Use Only

☐ **New Business**
☐ **Replacement/Conversion**
☐ **Addition to Existing**

IF YOU OR ANY PERSON PROPOSED FOR INSURANCE HAS EVER BEEN DECLINED FOR LIFE INSURANCE, DO NOT COMPLETE THIS APPLICATION.

SECTION A PROPOSED INSURED

1. Name: _____ Social Security Number: _____
2. Legal Residence Address: _____
3. Mailing Address for Premium Notice: _____
4. Secondary Addressee: _____
5. Are you and all persons proposed for insurance a citizen(s) of the United States? ☐ Yes ☐ No If "No," do all persons proposed for insurance have an alien registration receipt "Permanent Visa"? ☐ Yes ☐ No If "Yes," Permanent Visa No.: _____ Date of arrival in the United States: _____
6. Sex: ☐ Male ☐ Female Date of Birth: _____-_____-_____ Age: _____ Place of Birth: _____
7. Driver's License Number: _____ State of Issue: _____
8. Occupation: _____ Duties: _____
   Name of Firm or Employer: _____
9. Home Phone Number: ( ) _____ Best Time to Call: _____
10. Owner's Name (If different than Proposed Insured): _____
    Owner's Date of Birth: _____-_____-_____
    Owner's Social Security Number or Tax I.D. Number: _____
11. Beneficiary/Relationship: _____ SSN/TIN: _____
    Contingent Beneficiary/Relationship: _____ SSN/TIN: _____

SECTION B OTHER PROPOSED INSUREDS (SPOUSE/CHILDREN)

Complete Only If Spouse/Children Are Proposed For Insurance.

First Name, Middle Initial, Last Name	Social Security Number	Relationship to Proposed Insured	Birth Date Mo./Day/Yr.	Age	Sex

Spouse Occupation: _____ Place of Birth: _____
Spouse Driver's License #: _____ State of Issue: _____

SECTION C PLAN INFORMATION and OTHER COVERAGE

Plan(s) of Insurance _____ Amount: _____

Riders:

☐ Waiver of Premium/Disability (on Proposed Insured in Section A) ☐ Spouse Rider Amount: _____

☐ Accidental Death Benefit (on Proposed Insured in Section A) Amount: _____ ☐ Children's Rider (Units): _____

Death Benefit (Universal Life Only) ☐ Option 1: Specified Amount ☐ Option 2: Accumulation Value In Addition to Specified Amount
(If neither option is selected, Option 1 will be provided.)

Method of Payment: ☐ Monthly Bank Transfer ☐ Quarterly ☐ Semiannually ☐ Annual Planned Premium Amount: $ _____

Have you had or did you intend to have any life or annuity policy replaced, exchanged, converted, reduced, reissued or subject to borrowing because of this application? ☐ Yes ☐ No (If "Yes," list companies and policy numbers.) 1035 Exchange ☐ Yes ☐ No

_____

SECTION D **UNDERWRITING INFORMATION**

Have you or any person proposed for insurance used tobacco in any form in the last 12 months? ☐ Yes ☐ No

SECTION E **AGREEMENT SECTION**

I, the undersigned, and the undersigned Producer(s) certify that we have read the completed application or have had it read to us and agree to the following:

1. All answers in this application: (a) are true and complete to the best of my knowledge and belief; (b) will be relied on to determine insurability; and (c) which are incorrect or misleading, may void the application effective the issue date.
2. I understand that a paramedical examination will be performed. The Statements to Examiner form will be completed at that time and will be made part of this application.
3. If I am eligible for the policy applied for in accordance with the underwriting standards of United of Omaha Life Insurance Company, the effective date of coverage will be the same as the policy issue date.
4. No premium has been collected with this application. No policy of any kind will be in force unless: (a) any Proposed Insured for insurance is eligible for the coverage applied for; (b) prior to policy delivery there has been no change in either the health or habits of any Proposed Insured, or to the answers to any of the questions in the application; and (c) the first full premium is paid.
5. Before completing this application, I have received the following documents: The Notice of Exchange of Information; The Fair Credit Reporting Act Disclosure Statement; The Notice of Information Practices; A Summary of Your Rights Under the Fair Credit Reporting Act; and The Life Insurance Buyer's Guide.
6. If the Applicant is other than the Proposed Insured, the Applicant will own the policy.
7. No Producer can: (a) waive or change any receipt or policy provision or (b) agree to issue a policy.
8. **Applies to Variable Universal Life Only – I understand that the: (a) policy's accumulation value in the Variable Account is based on the investment experience in that account and will increase or decrease daily and is not guaranteed as to fixed dollar amount; and (b) amount of the death benefit may be fixed or variable, depending on the investment experience of the Variable Account. I hereby acknowledge that I have received a current Variable Life Prospectus. I request a Statement of Additional Information. ☐ (Check here)**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I have: (a) read the Agreements Section and (b) read and approved the answers as recorded.

Signed at: _____ Date _____
City State

_____ _____
Signature of Proposed Insured (Age 18 and Over) Signature of Spouse (If a Proposed Insured)

_____ _____
Signature of Parent or Guardian (If required in your State) Signature of Applicant/Owner/Trustee (If other than Proposed Insured)

In addition to the above Agreement, do you, the Producer, have any reason to believe the policy applied for has replaced or will replace any existing life insurance or annuity policy? (If "Yes," fulfill all state requirements.) ☐ Yes ☐ No

In the presence of the Proposed Insured/Spouse have you asked each question exactly as written and recorded the answer completely and accurately? (If "No," explain.) ☐ Yes ☐ No _____

For Variable Universal Life Only – By signing the line below I acknowledge that a copy of this application has been/will be submitted to my broker/dealer for suitability review.

Producer's Signature _____ Production Number _____
(Do not disclose social security number)

Producer's Name (Printed) _____ Phone Number _____

FL License Identification Number _____ BGA/Assistant Wholesaler _____

Agency Name/Broker Dealer _____

Date _____

AUTHORIZATION TO RELEASE INFORMATION TO UNITED OF OMAHA LIFE INSURANCE COMPANY

To all physicians, medical or dental practitioners, hospitals, clinics, other medical care facilities or other providers of medical or dental care services, insurers, employers and consumer reporting agencies:

I authorize you to release all medical and nonmedical information about me (the undersigned) or my children to United of Omaha Life Insurance Company, its affiliates, its reinsurers and any consumer reporting agency acting for them. This authorization includes information about medical history, mental and physical condition, drug and alcohol use, and other personal information such as finances, occupation and general reputation. I also authorize the preparation of a consumer report and/or investigative consumer report.

To the Medical Information Bureau, Inc. (MIB):

I authorize you to release all medical and nonmedical information about me (the undersigned) or my children to United of Omaha Life Insurance Company, its affiliates, and its reinsurers. This authorization includes information about medical history, mental and physical condition, drug and alcohol use, and other personal information.

I also authorize United of Omaha Life Insurance Company to report medical and nonmedical information about me (the undersigned) or my children to the Medical Information Bureau, Inc.

Information received will be used to determine insurability. This authorization is valid for 30 months from the date below. A photocopy of this authorization is as valid as the original. I have received the following documents: The Notice of Exchange of Information; The Fair Credit Reporting Act Disclosure Statement; The Notice of Information Practices; A Summary of Your Rights Under the Fair Credit Reporting Act; and The Life Insurance Buyer's Guide. I, or my authorized representative, will receive a copy of this authorization, upon request, and a copy of any investigative consumer report from the consumer reporting agency, upon request.

If an investigative consumer report is prepared, I may request to be interviewed. (Check if an interview is desired.) ☐

Name used for medical records: _____

_____ _____
Date Signature of Proposed Insured(s) (Age 18 or older)

_____ _____
Date Signature of Proposed Insured(s) (Age 18 or older)

_____ _____
Date Signature of Parent or Guardian (If required in your State)

AUTHORIZATION TO WITHDRAW FUNDS
TO
UNITED OF OMAHA LIFE INSURANCE COMPANY

I. List the policies/certificates to be paid by your checking account.

(1) _____ _____
Plan of Insurance — Proposed Insured

(2) _____ _____
Plan of Insurance — Proposed Insured

(3) _____ _____
Plan of Insurance — Proposed Insured

II. Complete the following only if you are adding the above coverages to an existing BSP account.

_____ _____
Insured Under Existing BSP — Existing BSP Policy Number

III. Specify the date premiums will be withdrawn (1st through the 28th of the month): _____

IV. _____ _____
Routing Number and Transit Number — Account Number

Or, attach your check from the account where premiums will be withdrawn.

As a convenience to me, I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to the appropriate Company(ies) listed above. Your rights with each charge will be the same as if personally paid by me. This authorization will be effective until I give you at least three business days notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

X _____ X _____ X _____
Date Mo./Day/Yr. — Authorized Signature as Shown on Account — Joint Account or Other Authorized Signature

ADDRESS INQUIRIES TO: UNITED OF OMAHA LIFE INSURANCE COMPANY
MUTUAL OF OMAHA PLAZA — OMAHA, NE 68175 OR CALL (800) 775-6000

NOTICE OF EXCHANGE OF INFORMATION

MEDICAL INFORMATION BUREAU, INC. (MIB)

The information regarding your insurability will be treated as confidential.

However, Mutual of Omaha Insurance Company and/or United of Omaha Life Insurance Company or their reinsurers may make a brief report to the Medical Information Bureau, Inc., a nonprofit membership organization of insurance companies which operates an information exchange for its members. If you apply for life or health insurance to another company which is also a member of the Bureau or if a claim for benefits is submitted to such a company, the Bureau will, upon request, supply the information in its file to that company.

Florida residents: However, no information obtained from the Medical Information Bureau pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will affect the issuance or the underwriting of the policy, except upon written consent to be medically tested for HIV or AIDS and the results of such testing proved positive.

Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, phone (617) 426-3660.

Mutual of Omaha Insurance Company and/or United of Omaha Life Insurance Company or their reinsurers may also release information in its file, including information given in your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, United of Omaha Life Insurance Company will rely heavily on information provided by you. The Company may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, consumer reporting agencies, or the Medical Information Bureau, Inc. (MIB).

In certain circumstances, and in compliance with applicable law, our Company may disclose personal or privileged information to third parties without your authorization.

You have the right to be told about and to see a copy, if you wish, of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE COMPANY'S INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, UNDERWRITING DEPARTMENT, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

FAIR CREDIT REPORTING ACT DISCLOSURE STATEMENT

Mutual of Omaha Insurance Company and/or United of Omaha Life Insurance Company, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights Under Section 606 (a) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address: Attention: Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, Nebraska 68175

GIVE THIS NOTICE TO THE APPLICANT

A Summary of Your Rights
Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRAs are credit bureaus that gather and sell information about you - such as if you pay your bills on time or have filed bankruptcy - to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681-1681u, at the Federal Trade Commission's web ste (*http://www.ftc.gov*). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state or local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information for a CRA to take action against you - such as denying an application for credit, insurance, or employment - must tell you, and give you the name, address, and phone number of the CRA that provided the consumer report.
- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested it recently. There is no charge for the report if a person has taken action against you because of information supplied by the CRA, if you request the report within 60 days of receiving notice of the action. You also are entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- **You can dispute inaccurate information with the CRA.** If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its findings to the CRA. (The source also must advise national CRAs - to which it has provided the data - of any error.) The CRA must give you a written report of the investigation, and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you may add a brief statement of your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or a dispute statement filed, you may ask that anyone who has recently received your report be notified of the change.
- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate or unverified information from its files, within 30 days after you dispute it. **However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified.** If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- **You can dispute inaccurate items with the source of the information.** If you tell anyone - such as a creditor who reports to a CRA - that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.
- **Outdated information may not be reported.** In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- **Access to your file is limited.** A CRA may provide information about you only to people with the need recognized by the FCRA - usually to consider an application with a creditor, insurer, employer, landlord, or other business.

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- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A CRA may not give out information about you to your employer, or prospective employer, without your written consent. A CRA may not report information about you to creditors, insurers, or employers without your permission.
- **You may choose to exclude your name from a CRA list for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete and return the CRA form provided for this purpose, you must be taken off the list indefinitely.
- **You may seek damages from violators.** If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA:

For Questions or Concerns Regarding:	**Please Contact:**
CRAs, creditors and others not listed below	Federal Trade Commission Consumer Response Center - FCRA Washington, DC 20580 202-326-3761
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies or foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks, (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Programs Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in the institutions name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-518-6360
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, DC 20429 800-934-FDIC
Air, surface, or rail common carrier regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 202-720-7051

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