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, 9330 State Hwy 133, Blair, NE 68008

Please use the precise Plan Name on the application to avoid app amends:

- ☐ Universal Life Plan names: Accum UL Plus or GUL Complete
- ☐ Universal Life Rider Names:
  - • Disability Rider, • Guaranteed Insurability Rider, • Accidental Death Benefit Rider,
  - • Children's Rider, and
  - ☐ Accum UL Plus only • Additional Insured Rider Self, • Additional Insured Rider Spouse,
  - • Additional Insured Rider Other Insured
- ☐ Term Plan Names: Term Life Answers and Term Life Complete
- ☐ Term Life Answers only - Other Insured Rider
- ☐ Term Life Complete only - Disability Income Rider
- ☐ Term Life Answers and Term Life Complete Riders:
  - • Waiver Premium • Accidental Death Benefit Rider, • Children's Rider

- ■ Children's Rider Application - Complete if applicable
- ■ If applying or any rider offering Disability Benefits, complete the Disability Income/Waiver supplemental application
- ■ Juvenile Life Insurance Supplemental Application - complete if Proposed Insured or Other Proposed Insured is age 0-17
- ■ Complete Monthly Bank Withdrawal form if applicable
- ■ Attach cover letter or additional information, as needed
  - ■ All changes should be initialed by the Applicant/Owner
- ☐ Always submit the Producer Statement and always provide client with MIB Group Inc Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Investigative Consumer Reports Notice, Summary of Rights, and Life Insurance Buyer's Guide
- ☐ Always obtain signed MIB and HIPAA authorizations
- ☐ If face amount is $100,000 or over – you will need a signed HIV consent form
- ☐ You will need a signed Accelerated Benefit Disclosure Form unless applying for Term Life Answers for a face amount more than $500,000.
- ☐ If face amount is $1,000,000 and above and the Proposed Insured is age 65 or over – you will need (a) signed Statement of Policyowner Intent and, (b) signed Premium Funding and Acknowledgement form
- ☐ **Do not collect a check for the initial premium** if any Proposed Insured is applying for more than $500,000 of insurance, nor if the answer to any of the 4 TIA questions are "yes."
  - ☐ **If a check for the initial premium is not collected at the time of application, check the box on the TIA form indicating that no money was collected, sign your name, and submit both copies of the TIA with the application.**
  - ☐ **If a check for the initial premium is collected at the time of application, complete two copies and leave the unsigned copy with the applicant.**
- ☐ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client
- ☐ **Have client sign state replacement forms (if applicable) and provide a copy to the client**

APPS 1-800-635-1677 PORTAMEDIC 1-800-765-1010 ExamOne 1-877-933-9261
EMSI 1-800-872-3674 Superior Mobile Medics 1-800-898-3926

- ☐ **Indicate underwriting requirements initiated or completed on the Proposed Insured(s)**

Primary Proposed Insured	**Other Proposed Insured:**
☐ Blood Profile	☐ Blood Profile
☐ Urinalysis	☐ Urinalysis
☐ Physical Data	☐ Physical Data
☐ Long Form Exam	☐ Long Form Exam
☐ EKG	☐ EKG
☐ Treadmill EKG	☐ Treadmill EKG
☐ MD Exam	☐ MD Exam

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

PART 1A, PAGE 1 OF 2 LIFE INSURANCE APPLICATION

PROPOSED INSURED

Proposed Insured Legal Name _____

Gender ☐ Male ☐ Female Height _____ Weight _____ Social Security No. _____

Date of Birth _____ State of Birth _____ Annual Income _____

Driver's License No _____ Driver's License State _____

Legal Residence Address _____

Best Time to Call _____ Phone No. _____ E-mail _____

Occupation/Duties _____ Employer _____

If Other Proposed Insured is age 0-17, complete Juvenile Supplemental Application

PLAN INFORMATION

Product Name _____ Amount of Insurance Applied for $ _____

☐ UL Option 1 Level Death Benefit ☐ UL Option 2 Specified Amount plus Accumulation Value

☐ Term Period _____ years ☐ Return of Premium Term

Rider Name	Rider Amount

Payment Mode ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft ☐ Other _____

Modal Premium $_____ Collected Premium $_____

OWNER

Complete Policyowner information if Proposed Insured is not the Policyowner

Name of Policyowner _____ Date of Birth _____

Relationship to Proposed Insured_____ Social Security No./Tax ID _____

Citizenship Country _____ Phone No. _____

Policyowner Address _____

Secondary Addressee – Optional. This person will receive copies of overdue premium and lapse notices.

Name _____

Mailing Address _____

If more space is needed, provide information in Comments section.

BENEFICIARY

Primary Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

Contingent Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

If more space is needed, provide information in Comments section.

OTHER COVERAGE INFORMATION

1. Have you or any person proposed for insurance been offered cash, or any other consideration for obtaining this policy? . . . . . ☐ Yes ☐ No
2. Are you or any Proposed Insured planning to enter into a finance arrangement to pay any premium payments due under this policy? . . . . . ☐ Yes ☐ No
3. Do you or any person proposed for insurance intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? . . . ☐ Yes ☐ No

If "Yes" to questions 1, 2 or 3, provide information in Comments section.

4. List below all life insurance policies and/or annuity contracts on any person proposed for insurance that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt.)

   If none, check the following box. . . . . ☐ None
5. Has any person proposed for insurance had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? . . . . . ☐ Yes ☐ No

Please complete the box(es) below.
The Producer shall comply with any additional state, and/or Company replacement requirements.

Company	Policy or Contract Number	Face Amount	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
					☐ Yes ☐ No	☐ Yes ☐ No	
					☐ Yes ☐ No	☐ Yes ☐ No	
					☐ Yes ☐ No	☐ Yes ☐ No	
					☐ Yes ☐ No	☐ Yes ☐ No	
					☐ Yes ☐ No	☐ Yes ☐ No	

COMMENTS

Provide any additional information necessary and the details of "Yes" answers. Always identify question number.

RIDER ON OTHER PROPOSED INSURED

Other Proposed Insured Legal Name _____

Gender ☐ Male ☐ Female Height _____ Weight _____ Social Security No. _____

Date of Birth _____ State of Birth _____ Annual Income _____

Driver's License No _____ Driver's License State _____

Legal Residence Address _____

Best Time to Call _____ Phone No. _____ E-mail _____

If Other Proposed Insured is age 0-17, also complete Juvenile Supplemental Application

Occupation/Duties _____ Employer _____

Primary Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

Contingent Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

If more space is needed, provide information in Comments section

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

PART 1B, PAGE 1 OF 1 LIFE INSURANCE APPLICATION

NON-MEDICAL UNDERWRITING

	Proposed Insured	Other Proposed Insured Rider
1. Are the persons proposed for insurance citizens of the United States? . . . . . **If "No," complete the Foreign National questionnaire.**	☐Yes ☐No	☐Yes ☐No
2. Has any person proposed for insurance ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy? . . . . . **If "Yes," to question 2, please list details below.**	☐Yes ☐No	☐Yes ☐No

Person Proposed for Insurance	Form of Tobacco/Nicotine Replacement Therapy	Number per Day	Date Stopped

	Proposed Insured	Other Proposed Insured Rider
3. Has any person proposed for insurance **If answered "Yes," please list details in the Comments section.**		
(a) had life insurance coverage declined, postponed, or limited, or been denied reinstatement, or asked to pay extra premium by any insurance company?	☐Yes ☐No	☐Yes ☐No
(b) engaged in parachuting, hang gliding, rock or mountain climbing, skydiving, skin diving or scuba diving, cliff diving, organized motor vehicle or boat racing, base jumping or bungee jumping, within the last three years, or plan such activity in the next two years? . . . . . **If "Yes," complete the appropriate questionnaire.**	☐Yes ☐No	☐Yes ☐No
(c) any intention of traveling, or living outside the USA, or Canada in the next two years? **If "Yes," complete the Foreign Travel questionnaire.**	☐Yes ☐No	☐Yes ☐No
(d) flown as a civilian pilot, student pilot, or crew member within the last three years, or plan such activity in the next two years? . . . . . **If "Yes," complete the Aviation questionnaire.**	☐Yes ☐No	☐Yes ☐No
(e) within the last five years (1) been convicted of two or more moving violations, or (2) been convicted of driving under the influence of alcohol, or drugs, or (3) had a driver's license suspended, or revoked?	☐Yes ☐No	☐Yes ☐No
(f) been convicted of a felony, or have been incarcerated within the last 10 years?	☐Yes ☐No	☐Yes ☐No
(g) been on probation within the last 12 months, or are currently on probation?	☐Yes ☐No	☐Yes ☐No

FINANCES

		Other Proposed Insured Rider
4. Has any person proposed for insurance ever filed for bankruptcy?	☐Yes ☐No	☐Yes ☐No

If "Yes," please provide type(s) and date(s) _____

5. What is the purpose of this insurance (e.g., income replacement, mortgage protection, key person, buy-sell)?

_____

6. If applying for $500,000 or more, complete box(es) below.

Person Proposed for Insurance	Total Assets	Total Liabilities	Net Worth	Earned Income	Unearned Income

FAMILY HISTORY

7. Family History – Please list details below for both Proposed Insured and Other Proposed Insured (if applicable), or if not applicable check here ☐

	Age at Death	Age at Death	If Deceased, Cause of Death	
	Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

PART 2, PAGE 1 OF 3 LIFE INSURANCE APPLICATION

MEDICAL UNDERWRITING

	Proposed Insured	Other Proposed Insured Rider
1. Does any person proposed for insurance currently have a personal physician?	☐ Yes ☐ No	☐ Yes ☐ No

Person Proposed for Insurance	Name, Address and Telephone Number of Personal Physician	Date last seen	State Reason, Findings and Treatment

2. Has any person proposed for insurance ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Has any person proposed for insurance ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:		
(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke?	☐ Yes ☐ No	☐ Yes ☐ No
(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, or shortness of breath?	☐ Yes ☐ No	☐ Yes ☐ No
(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries?	☐ Yes ☐ No	☐ Yes ☐ No
(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	☐ Yes ☐ No	☐ Yes ☐ No
(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
(g) any disease, or disorder of vision, or hearing?	☐ Yes ☐ No	☐ Yes ☐ No
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/ metabolic disorder?	☐ Yes ☐ No	☐ Yes ☐ No
4. **In the past 10 years,** has any person proposed for insurance		
(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a physician, or other health care provider?	☐ Yes ☐ No	☐ Yes ☐ No
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	☐ Yes ☐ No	☐ Yes ☐ No
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous? . .	☐ Yes ☐ No	☐ Yes ☐ No
5. **In the past 12 months**, has any person proposed for insurance:		
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?	☐ Yes ☐ No	☐ Yes ☐ No
(b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy?	☐ Yes ☐ No	☐ Yes ☐ No
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? . .	☐ Yes ☐ No	☐ Yes ☐ No
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL UNDERWRITING

6. In the past two years, has any person proposed for insurance, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? . . . . . ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

If answered "Yes," please list details below.
If more space is needed use the Comments section.

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date Last Taken	Prescribing Physician (if any)	Reason	Dosage / Frequency

7. In the past five years, has any person proposed for insurance consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? . . . . ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

If answered "Yes," please list details below.
If more space is needed use the Comments section.

Person Proposed for Insurance	Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

COMMENTS

List details of "Yes" answers. Identify question number and circle applicable items: Include diagnosis, dates, prescription medications, duration, and names and addresses of all attending physicians and medical facilities. Use additional sheet of paper if necessary.

AGREEMENT

Each of the undersigned, including the Producer(s), certify that we have read the completed application.

1. All answers in this application are true and complete, to the best of my knowledge and belief, and will be relied on by United of Omaha to determine insurability. The statements and answers in the application are the basis for any policy issued by United of Omaha, and no information about them will be considered to have been given to United of Omaha unless it is stated in the application. Any incorrect or misleading answers may void this application and any issued policy effective the issue date.
2. If mode of payment is Bank Service Plan, I/We authorize premiums due to be automatically paid to United of Omaha, by electronic fund transfer until this authorization is cancelled in writing.
3. Until this application is approved for issue by United of Omaha's Underwriting Department, no policy will be issued and no coverage will be provided except by a Temporary Insurance Agreement, if provided. In no event will benefits be paid for the same loss under both a Temporary Insurance Agreement and any policy issued from this application.
4. The issue date of the policy will be the date shown in the policy, even though coverage may not become effective until a later date. Coverage under the issued policy will become effective only if and when: (a) the full initial premium is paid or, if paid by electronic funds transfer, the full initial premium is received by United of Omaha, (b) United has been notified of any change in either the health or habits of any person proposed for insurance between the date the application is approved for issue and the date the policy is delivered, and (c) the policy is delivered and all delivery requirements (including a signed good health statement if required) are completed during the lifetime of the Proposed Insured.
5. If, prior to policy delivery, any person proposed for insurance dies, or there has been a change in that person's health or habits that will change any statement or answer to any question in the application, we will immediately notify United of Omaha. If the person proposed for insurance is not eligible for the insurance applied for, we agree that no policy of any kind will be in effect.
6. I have received the MIB Group, Inc. Pre-Notice, the Notice of Information Practices, and a Life Insurance Buyer's Guide before completing this application.
7. If the applicant is other than the person proposed for insurance, the applicant will own the policy.
8. No Producer can: (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.
9. **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.

The application includes Parts IA, Part 1B, Part 2 and all approved supplemental forms or amendments the Insurer specifically designates as parts of the application, by attaching as part of any policy delivered to the Owner.

I have read and understand the Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB"), the Authorization to Disclose Personal Information to United of Omaha Life Insurance Company and the Agreement Section, and I approve all my answers as recorded in this application.

Signed at: _____ _____ Date _____
City State Mo Day Yr

_____
Signature of Proposed Insured age 15 and Over

_____
Signature of Applicant/Owner/Trustee if other than Proposed Insured **or** if the Owner is a corporation, trust, or other entity. Include title of Signee(s).

_____
Signature of Other Proposed Insured age 15 and Over

_____
Signature of Applicant/Owner/Trustee if other than Other Proposed Insured **or** if the Owner is a corporation, trust, or other entity. Include title of Signee(s).

_____
Signature of Payor as shown on bank account if Payment mode is BSP **and** payor is other than Proposed Insured or Other Proposed Insured.

_____
Signature of Parent or Guardian if Proposed Insured is under Age 15

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Producer Statement

1. In addition to the Agreement, has any person proposed for insurance informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? . . . . ☐ **Yes** ☐ **No**
If "Yes," give name(s) of the person(s) _____

_____

2. Do you, the Producer(s), know or have reason to believe that the policy(ies) applied for has replaced or will replace any existing life insurance policies or annuity contracts? . . . . . ☐ **Yes** ☐ **No**

3. Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer's Guide and comply with all state and Company replacement requirements? ☐ **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**
If "No," please explain _____

_____

_____

5. I conducted said interview in person ☐ **Yes** ☐ **No** **If "No," please explain** _____

_____

_____

_____ _____ _____
Signature of Producer # 1 Production Number Mo Day Yr

_____ _____ _____
Signature of Producer # 2 Production Number Mo Day Yr

_____
Print or Stamp Producer #1 Name

_____
Print or Stamp Producer #2 Name

_____ _____
General Agent/General Manager Name General Agent/General Manager Stamp

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United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

MONTHLY BANK WITHDRAWALS BY UNITED OF OMAHA LIFE INSURANCE COMPANY ("United of Omaha")

The withdrawal from the bank account identified below for the initial premium(s) due will occur only if and when the application(s) is/are approved for issue by United of Omaha. The withdrawal for renewal premiums due will occur on the date specified below.

- Social Security No. of Payor – if other than Proposed Insured or Owner
- Specify the date renewal premiums will be withdrawn (1st through the 28th of each month)
- If no date is specified, renewal premiums will be withdrawn each month on the day that matches the policy issue date.

AUTHORIZATION TO WITHDRAW FUNDS BY UNITED OF OMAHA LIFE INSURANCE COMPANY ("United of Omaha")

(If Mode of Payment is Monthly BSP - select one below)

☐ Monthly Bank Service Plan **(initial premium collected with the application)**

☐ Monthly Bank Service Plan **(initial premium** to be paid by electronic transfer)

Complete information below OR attach a voided check**:**

Routing No. (9-digit No.. See sample check below)

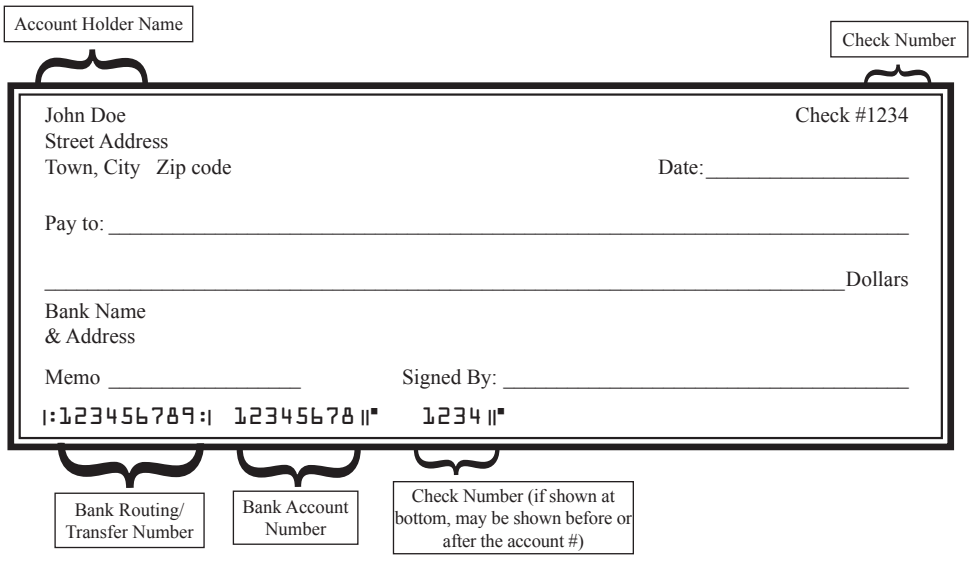
Account No.

Name of Payor as shown on account

First Initial

Last

ATTACH CHECK HERE



Submit To Home Office

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

To: physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, MIB (Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members), insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of Mutual of Omaha Insurance Company or its affiliated companies (Mutual), personal information about me including: medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information in order to determine eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with a claim.

I also authorize Mutual to disclose my personal information to the MIB. I understand that my personal information received by the 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.

I understand that I may refuse to sign this authorization. I realize if I refuse to sign, the insurance for which I am applying will not be issued.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. This revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Name(s) used for medical records (if different than the name) below: _____

_____

_____ **Date:** _____

Signature of Proposed Insured Mo Day Yr

_____ **Date:** _____

Signature of Spouse (If Proposed Insured) Mo Day Yr

_____ **Date:** _____

Signature of Parent or Guardian (if Proposed insured is a minor) Mo Day Yr

_____ **Date:** _____

Signature of Non-minor Child (If Proposed Insured is a Non-minor) Mo Day Yr

L8232

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Accelerated Benefit Rider Disclosure

When the Accelerated Benefit is paid under the terms of this rider, the life insurance policy to which this rider is attached will terminate. The Accelerated Benefit may be taxable. Receipt of this 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 this Benefit.

This rider is part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the rider provisions. This rider is effective on the policy's date of issue.

Accelerated Benefit

While this rider is in force, you may make a one-time election to receive the Accelerated Benefit if the Insured is diagnosed as having a Terminal Illness. **Terminal Illness** means a medical condition that, with a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

The Accelerated Benefit amount will equal:
(a) 94% of the net death benefit of the policy; plus
(b) 94% of any term insurance rider on the Insured's life that is attached to the policy.

The Accelerated Benefit is not available if the sum of the death benefit under the policy and the death benefit under any term insurance rider on the Insured's life is greater than $500,000.

There is no premium or cost of insurance charge for this benefit.

Term life insurance riders, if attached to the base plan, will be terminated, but are included in the Accelerated Benefit calculation. Non-term life insurance riders such as the Accidental Death Benefit will terminate when the Accelerated Benefit option is invoked.

Any outstanding loans will be deducted from the death benefit before the Accelerated Benefit is calculated.

Termination

The policy and all riders attached to it will terminate when the Accelerated Benefit is paid. Any rider that covers the life of another person and that includes a conversion provision may be converted to a new policy as specified in the rider.

This rider will terminate on the earliest of the following:
(a) the date the Accelerated Benefit is paid;
(b) the date the policy terminates; or
(c) the maturity date of the policy.

For Use
with
Term Life Answers

I acknowledge receipt of this Disclosure Form.

_____ _____
Applicant/Owner Signature Date

Producer Statement (if applicable):

I have provided this Disclosure Form to the Applicant.

_____ _____
Producer Signature Date

Temporary Life Insurance Agreement and Receipt ("Agreement")

United of Omaha Life Insurance Company ("United," "We," "Our," "Us"), Mutual of Omaha Plaza, Omaha, NE 68175

****THIS AGREEMENT MUST BE RETURNED WITH THE APPLICATION TO THE HOME OFFICE.**

FACE AMOUNT REQUIREMENTS:
- **Total amount of insurance applied for cannot exceed $500,000.**
- If the total amount of insurance applied for exceeds $500,000, **NO MONEY** can be collected and no coverage will be in effect under this Agreement.

HEALTH QUESTION REQUIREMENT:
- **If a question below is answered "Yes," NO MONEY can be collected and no coverage is in effect under this Agreement.**

PAYMENT REQUIREMENT:
Payment must be made by check; no credit cards or cash.
Checks must be made out to United of Omaha.
Do not make checks out to the Producer.
The full initial premium must be provided (2 months for BSP). The Agreement and premium must be submitted with the application. The Agreement and/or premium cannot be submitted at a later date.

If any of the questions listed below are answered "Yes" or not answered, no Producer of United is authorized to complete this Agreement, or accept money with the application, and no coverage will take effect under this Agreement.

		YES	NO
1	Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, had surgery performed or recommended, or been advised to have a diagnostic test other than an HIV test?	☐	☐
2	Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider?	☐	☐
3	Has any Proposed Insured ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or been treated for or had treatment recommended for AIDS or ARC by a physician or other health care provider?	☐	☐
4	Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐

☐ **No money was collected with the application on** _____ **and this Temporary Insurance Agreement is not in effect.**
Proposed Insured(s)

Producers' Signature(s): _____ **Date**_____ **(STOP. DO NOT CONTINUE.)**

In consideration of the application and payment of $ _____ by the Applicant, receipt of which is hereby acknowledged, United agrees to provide temporary life insurance for the Proposed Insured(s) effective on the date of the application, for a limited period of time, subject to the following conditions and limitations.

A If the correct answer to any of the above questions is "Yes," or the answer given above is incorrect or misleading, or if any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.

B Temporary life insurance under this Agreement will automatically terminate on the earliest of the following dates:
(1) 90 days from the date of this Agreement, except in Connecticut; or
(2) the date that insurance takes effect under the policy applied for; or
(3) the date of the letter offering to the Applicant a policy, other than applied for; or
(4) the date a policy, other than as applied for, is offered by an Producer to the Applicant; or
(5) the date the premium refund is mailed; or
(6) the date any check or draft submitted as payment is not honored by the bank on which it is drawn; or
(7) the date United mails notice of termination of coverage.

C If the policy applied for is either (a) pursuant to a conversion privilege in (an) existing United life policy(ies), or (b) to replace (an) existing United life policy(ies) with another United life policy, then in the event of the death of the Proposed Insured before the termination of this Agreement, United will pay only the greater of:
(1) the benefits due under the terms of the existing policy(ies) which is/are being converted or replaced, or
(2) the benefits due under the terms of this Agreement.
The Applicant acknowledges and agrees that benefits shall not be payable under both, C.(1) and C.(2) above.

D The temporary life insurance provided by this Agreement is subject to the provisions of the policy form applied for; however, no benefits will be paid for:
(1) disability; or
(2) death from suicide while sane or insane (in Missouri, only if suicide was intended at the time of this application and we can prove it was intended); or
(3) the same loss under both this Agreement and any life policy issued from the application.

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement limit or waive any rights under any life insurance policy issued. If the application is rejected by United, the amount paid with the application will be refunded to the Applicant regardless of whether a claim has been filed or benefits have been paid under this Agreement.
No change may be made to the terms and conditions of this Agreement by anyone, including the Producer.
If any Proposed Insured meets the terms of this Agreement and dies prior to the termination of this Agreement, United will pay the beneficiary the face amount applied for (unless otherwise required by C above), not to exceed $500,000.
I have read and received a copy of this Agreement and understand and agree to all of its terms. I verify the above answers are true and complete.

Signed this _____ day of _____, _____, at _____
City State ZIP Code

Printed Name of Proposed Insured	Signature of Proposed Insured
Printed Name of Applicant (if other than Proposed Insured)	Signature of Applicant
Printed Name of Spouse (if a Proposed Insured)	Signature of Spouse
Printed Name of Producer(s)	Signature of Producer(s)

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

☐ ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
☐ ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result, you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

Other Sources of Information

For more added information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

Consent for HIV Testing

I have read and I understand this HIV test Informed consent form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies and the disclosure of the test results as described above. I will be given a copy of this form. This consent is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications as appropriate, within this 90 (ninety) day period.

In the event of a positive test result:

_____ Send the result to me at:

Address: _____

_____ I authorize (name of insurer) to send the result to another person:

Name: _____ _____

Address: _____

_____ I authorize (name of insurer) to send the result to the following physician or health care provider:

Physician's Name: _____

Address: _____

Authorization _____

Name of applicant _____

_____
Signature of applicant date

_____
Signature of legal guardian, if any date

_____
Signature of person obtaining consent date

Client Forms
FOLLOW THIS PAGE

Producer: TIA agreement
The customer copy must be submitted to the home office and not given to the applicant **IF A CHECK FOR THE INITIAL PREMIUM WAS NOT COLLECTED** at the time of application.

Temporary Life Insurance Agreement and Receipt ("Agreement")

United of Omaha Life Insurance Company ("United," "We," "Our," "Us"), Mutual of Omaha Plaza, Omaha, NE 68175

****APPLICANT'S COPY** LEAVE WITH THE APPLICANT ONLY IF ALL REQUIREMENTS OF THIS AGREEMENT ARE MET AND MONEY IS COLLECTED.**

FACE AMOUNT REQUIREMENTS:
- **Total amount of insurance applied for cannot exceed $500,000.**
- If the total amount of insurance applied for exceeds $500,000, **NO MONEY** can be collected and no coverage will be in effect under this Agreement.

HEALTH QUESTION REQUIREMENT:
- **If a question below is answered "Yes," NO MONEY can be collected and no coverage is in effect under this Agreement.**

PAYMENT REQUIREMENT:
Payment must be made by check; no credit cards or cash.
Checks must be made out to United of Omaha.
Do not make checks out to the Producer.
The full initial premium must be provided (2 months for BSP). The Agreement and premium must be submitted with the application. The Agreement and/or premium cannot be submitted at a later date.

If any of the questions listed below are answered "Yes" or not answered, no Producer of United is authorized to complete this Agreement, or accept money with the application, and no coverage will take effect under this Agreement.

		YES	NO
1	Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, been advised to be admitted, had surgery performed or recommended, or been advised to have a diagnostic test other than an HIV test?	☐	☐
2	Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider?	☐	☐
3	Has any Proposed Insured ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the Human Immunodeficiency Virus (HIV) infection or been treated for or had treatment recommended for AIDS or ARC by a physician or other health care provider?	☐	☐
4	Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐

☐ **No money was collected with the application on** _____ **and this Temporary Insurance Agreement is not in effect.**
Proposed Insured(s)

Producers' Signature(s): _____ **Date**_____ **(STOP. DO NOT CONTINUE.)**

In consideration of the application and payment of $ _____ by the Applicant, receipt of which is hereby acknowledged, United agrees to provide temporary life insurance for the Proposed Insured(s) effective on the date of the application, for a limited period of time, subject to the following conditions and limitations.

A If the correct answer to any of the above questions is "Yes," or the answer given above is incorrect or misleading, or if any of the answers to the questions on the application are incorrect or misleading, then this Agreement is void and never went into effect.

B Temporary life insurance under this Agreement will automatically terminate on the earliest of the following dates:
(1) 90 days from the date of this Agreement, except in Connecticut; or
(2) the date that insurance takes effect under the policy applied for; or
(3) the date of the letter offering to the Applicant a policy, other than applied for; or
(4) the date a policy, other than as applied for, is offered by an Producer to the Applicant; or
(5) the date the premium refund is mailed; or
(6) the date any check or draft submitted as payment is not honored by the bank on which it is drawn; or
(7) the date United mails notice of termination of coverage.

C If the policy applied for is either (a) pursuant to a conversion privilege in (an) existing United life policy(ies), or (b) to replace (an) existing United life policy(ies) with another United life policy, then in the event of the death of the Proposed Insured before the termination of this Agreement, United will pay only the greater of:
(1) the benefits due under the terms of the existing policy(ies) which is/are being converted or replaced, or
(2) the benefits due under the terms of this Agreement.
The Applicant acknowledges and agrees that benefits shall not be payable under both, C.(1) and C.(2) above.

D The temporary life insurance provided by this Agreement is subject to the provisions of the policy form applied for; however, no benefits will be paid for:
(1) disability; or
(2) death from suicide while sane or insane (in Missouri, only if suicide was intended at the time of this application and we can prove it was intended); or
(3) the same loss under both this Agreement and any life policy issued from the application.

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement limit or waive any rights under any life insurance policy issued. If the application is rejected by United, the amount paid with the application will be refunded to the Applicant regardless of whether a claim has been filed or benefits have been paid under this Agreement.
No change may be made to the terms and conditions of this Agreement by anyone, including the Producer.
If any Proposed Insured meets the terms of this Agreement and dies prior to the termination of this Agreement, United will pay the beneficiary the face amount applied for (unless otherwise required by C above), not to exceed $500,000.
I have read and received a copy of this Agreement and understand and agree to all of its terms. I verify the above answers are true and complete.

Signed this _____ day of _____, _____, at _____
City State ZIP Code

Printed Name of Proposed Insured	Signature of Proposed Insured
Printed Name of Applicant (if other than Proposed Insured)	Signature of Applicant
Printed Name of Spouse (if a Proposed Insured)	Signature of Spouse
Printed Name of Producer(s)	Signature of Producer(s)

Accelerated Benefit Rider Disclosure

When the Accelerated Benefit is paid under the terms of this rider, the life insurance policy to which this rider is attached will terminate. The Accelerated Benefit may be taxable. Receipt of this 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 this Benefit.

This rider is part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the rider provisions. This rider is effective on the policy's date of issue.

Accelerated Benefit

While this rider is in force, you may make a one-time election to receive the Accelerated Benefit if the Insured is diagnosed as having a Terminal Illness. **Terminal Illness** means a medical condition that, with a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date a physician signs the statement of proof of Terminal Illness.

The Accelerated Benefit amount will equal:
(a) 94% of the net death benefit of the policy; plus
(b) 94% of any term insurance rider on the Insured's life that is attached to the policy.

The Accelerated Benefit is not available if the sum of the death benefit under the policy and the death benefit under any term insurance rider on the Insured's life is greater than $500,000.

There is no premium or cost of insurance charge for this benefit.

Term life insurance riders, if attached to the base plan, will be terminated, but are included in the Accelerated Benefit calculation. Non-term life insurance riders such as the Accidental Death Benefit will terminate when the Accelerated Benefit option is invoked.

Any outstanding loans will be deducted from the death benefit before the Accelerated Benefit is calculated.

Termination

The policy and all riders attached to it will terminate when the Accelerated Benefit is paid. Any rider that covers the life of another person and that includes a conversion provision may be converted to a new policy as specified in the rider.

This rider will terminate on the earliest of the following:
(a) the date the Accelerated Benefit is paid;
(b) the date the policy terminates; or
(c) the maturity date of the policy.

I acknowledge receipt of this Disclosure Form.

_____ _____
Applicant/Owner Signature Date

Producer Statement (if applicable):

I have provided this Disclosure Form to the Applicant.

_____ _____
Producer Signature Date

HIV Test Informed Consent Form

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

☐ ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
☐ ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The tests that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It may also result in uninsurability for life, health or disability insurance for which you may apply in the future.

Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to the HIV are found in the blood or other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

PRE TESTING CONSIDERATION:

Many public health organizations have recommended that before taking an HIV virus antibody test a person should seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

DISCLOSURE OF TEST RESULTS:

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The insurer may not by law release positive test results, except as provided below.

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a nonspecific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

TEST RESULTS:

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

☐ ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
☐ ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
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Other Sources of Information

For more added information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437). The hotline is a free call.

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In the event of a positive test result:

_____ Send the result to me at:

Address: _____

_____ I authorize (name of insurer) to send the result to another person:

Name: _____ _____

Address: _____

_____ I authorize (name of insurer) to send the result to the following physician or health care provider:

Physician's Name: _____

Address: _____

Authorization _____

Name of applicant _____

_____
Signature of applicant date

_____
Signature of legal guardian, if any date

_____
Signature of person obtaining consent date

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.

- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
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 of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 1-202-452-3693
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 Complaints Washington, DC 20552 1-800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 1-703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation , Office of Financial Management Washington, DC 20590 1-202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 1-202-720-7051

United of Omaha Life Insurance Company – MIB Group, Inc. 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, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. 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 (TTY 866-346-3642). 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, Boston, 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.

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 609 (c) 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.

United of Omaha Life Insurance – Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy 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.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR 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, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

Investigative Consumer Reports Notice

United of Omaha Life Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.