

SERFF Tracking Number: MUTM-125727010 State: Arkansas
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 39567
Company Tracking Number: AMY PEITZ
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life Application - C497LNA08A
Project Name/Number: New Fixed Life Application /C497LNA08A

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Individual Life Application - C497LNA08A SERFF Tr Num: MUTM-125727010 State: ArkansasLH

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 39567

Sub-TOI: L08.000 Life - Other

Co Tr Num: AMY PEITZ

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Authors: Shelly Kaipust, Kim

Disposition Date: 07/10/2008

Meyerring, Jan Serafini, Gilbert

Burket, Krysia Gannon, Amy Peitz,

Robyn Gonzales, Joanne Najdzin

Date Submitted: 07/09/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: New Fixed Life Application

Status of Filing in Domicile: Pending

Project Number: C497LNA08A

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/10/2008

State Status Changed: 07/10/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: United of Omaha Life Insurance Company

NAIC 261-69868 FEIN 47-0322111

Form C497LNA08A - New Fixed Life Insurance Application

SERFF Tracking Number: MUTM-125727010 *State:* Arkansas
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On behalf of United of Omaha Life Insurance Company, I am submitting the above-captioned form in final format for review and approval. It contains no unusual or controversial items according to normal company and industry standards.

Application C497LNA08A is similar to application 8445L-0603, which was approved by your Department on August 18, 2003. The differences between the new form and the previously approved form are shown in the attached red-lined version, included in Supporting Documents as Attachment A.

No other changes have been made to the application.

Application C497LNA08A will be used to apply for any approved life insurance products that require full medical underwriting. Because this application is intended for use with multiple products, the Plan Information section "Section J" is being submitted as variable. It will be amended to reflect new benefit options and riders, as they become available.

Please except our assurances that the Flesch score of the application when combined with the policy meets the minimum score of 40.

Enclosed are the required filing materials. Thank you for your consideration of this submission.

Sincerely,

Amy Peitz
Product and Advertising Compliance Analyst
Regulatory Affairs
Phone: 402-351-2449
Fax: 402-351-5298
E-mail: Amy.Peitz@mutualofomaha.com

Company and Contact

SERFF Tracking Number: MUTM-125727010 State: Arkansas
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Filing Contact Information

Amy Peitz, Product & Advertising Compliance amy.peitz@mutualofomaha.com
 Analyst
 4 - Regulatory Affairs Division (402) 351-2449 [Phone]
 Omaha, NE 68175 (402) 351-5298[FAX]

Filing Company Information

United of Omaha Life Insurance Company CoCode: 69868 State of Domicile: Nebraska
 Mutual of Omaha Plaza Group Code: 261 Company Type: Life Insurance
 Omaha, NE 68175 Group Name: State ID Number:
 (402) 351-6420 ext. [Phone] FEIN Number: 47-0322111

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation: 1 Application = \$20.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$20.00	07/09/2008	21316508

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	07/10/2008	07/10/2008

SERFF Tracking Number: MUTM-125727010 State: Arkansas
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Disposition

Disposition Date: 07/10/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MUTM-125727010 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	AR Fee Schedule Cert		Yes
Supporting Document	Attachment A - 8445L-0603 Red-lined		Yes
Form	Application for Life Insurance		Yes

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Form Schedule

Lead Form Number: C497LNA08A

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	C497LNA08A	Application/ Enrollment Form	Application for Life Insurance	Initial		40	C497LNA08A.pdf

Application for Life Insurance

UNITED OF OMAHA LIFE INSURANCE COMPANY

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

<input type="checkbox"/> ADULT LIFE	<input type="checkbox"/> New Business
<input type="checkbox"/> JUVENILE LIFE	<input type="checkbox"/> Term Conversion
<input type="checkbox"/> Replacement or	
<input type="checkbox"/> Rate Reconsideration	
<input type="checkbox"/> Addition to Existing Policy # _____	



Section A Proposed Insured Information

Use Black or Blue Ink and All Capital Letters

1 Proposed Insured _____
First Name Initial

_____ Last Name

2 Social Security Number _____ Age _____ Male Female

3 Birth Date _____ Height _____ Weight _____ Birth State _____
MM DD YY

4 Driver's License Number _____ State of Issue _____

5 Legal Residence Address _____
Street

_____ City _____ State _____ ZIP _____

6 Mailing Address (if different than above) _____

7 Phone Number (____) _____ Alternate Phone Number (____) _____

8 Best Time to Call ____:____ a.m. p.m. E-mail Address (Optional) _____

9 Occupation and Duties _____

10 Name of Employer _____

11 Annual Income _____

12 Secondary Addressee Information (Optional): Please provide name and address. A copy of any notification of possible policy lapse will be sent to this person. _____

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

1 Owner's Name (if other than Proposed Insured) _____
First Name Initial

_____ Last Name or Company Name

2 Tax ID Number _____ or Social Security Number _____

3 Birth Date _____ Male Female Relationship to Proposed Insured _____
MM DD YY

4 Owner's Legal Address _____
Street

_____ State _____ ZIP _____

5 Phone Number (____) _____ E-mail Address (Optional) _____

6 Are you a citizen of the United States? (If "No," list details below.) Yes No

Documentation	Date of Arrival in the United States
<input type="checkbox"/> Permanent Resident Card (card number _____)	/ /
<input type="checkbox"/> Visa (specify type _____)	

Section B

Other Proposed Insured Information

<input type="checkbox"/> Other Proposed Insured Will Be Covered By A Separate Policy	<input type="checkbox"/> Other Proposed Insured Will Be Covered By A Rider
--	--

1 Other Proposed Insured _____
First Name Initial

Last Name

2 Social Security Number _____ Age _____ Male Female

3 Birth Date _____ Height _____ Weight _____ Birth State _____
MM DD YY

4 Driver's License Number _____ State of Issue _____

5 Legal Residence Address _____
Street

City State ZIP

6 Mailing Address (if different than above) _____

7 Relationship to Proposed Insured _____

8 Phone Number _____ Alternate Phone Number _____

9 Best Time To Call ____:____ a.m. p.m. E-mail Address (Optional) _____

10 Occupation and Duties _____

11 Name of Employer _____

12 Annual Income _____

13 Secondary Addressee Information (Optional): Please provide name and address. A copy of any notification of possible policy lapse will be sent to this person. _____

**Owner/Applicant Information (Complete only if Owner/Applicant is different from Other Proposed Insured)
 DO NOT COMPLETE THIS SECTION IF THE OTHER PROPOSED INSURED IS TO BE COVERED BY A RIDER**

1 Owner's Name (if other than Other Proposed Insured) _____
First Name Initial

Last Name or Company Name

2 Tax ID Number _____ or Social Security Number _____

3 Birth Date _____ Male Female Relationship to Other Proposed Insured _____
MM DD YY

4 Owner's Legal Address _____
Street

City State ZIP

5 Phone Number _____ E-mail Address (Optional) _____

6 Are you a citizen of the United States? (If "No," list details below.) Yes No

Documentation	Date of Arrival in the United States
<input type="checkbox"/> Permanent Resident Card (card number _____)	/ /
<input type="checkbox"/> Visa (specify type _____)	

Section C Juvenile Coverage Information (Complete only if Primary Insured is a Juvenile)

1	Total Amount of life insurance in force. If "None," check box below.	Total Amount of Accidental Death (AD&D) insurance in force. If "None," check box below.
Proposed Insured	\$ _____ OR <input type="checkbox"/> None	\$ _____ OR <input type="checkbox"/> None
Name of Parent or Legal Guardian	\$ _____ OR <input type="checkbox"/> None	\$ _____ OR <input type="checkbox"/> None
Name of Parent or Legal Guardian	\$ _____ OR <input type="checkbox"/> None	\$ _____ OR <input type="checkbox"/> None

2 Does the Proposed Insured live with the Owner/Applicant? **Yes** **No**
(If "No," please give details below.)

Reason _____

Name, Address and Relationship of the person with whom the Proposed Insured is living with _____

3 Does the Proposed Insured have any minor brothers or sisters? **Yes** **No**
(If "Yes," please give details below.)

Name	Age	Total Amount of life insurance in force	If not insured, please state reason

Section D Underwriting Information (Complete for Proposed Insured and Other Proposed Insured)

	Proposed Insured		Other Proposed Insured	
	Yes	No	Yes	No
1 Are the persons proposed for insurance citizens of the United States?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(If "No," complete Foreign National Questionnaire and list details below.)

Person Proposed for Insurance	Documentation	Date of Arrival in the United States
Proposed Insured	<input type="checkbox"/> Permanent Resident Card (card number _____) <input type="checkbox"/> Visa (specify type _____)	/ /
Other Proposed Insured	<input type="checkbox"/> Permanent Resident Card (card number _____) <input type="checkbox"/> Visa (specify type _____)	/ /

2 Have any of the persons proposed for insurance used (a) any form of tobacco or (b) any form of nicotine replacement therapy? **Yes** **No** **Yes** **No**

(If "Yes," to question 4, please list details below.)

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

If questions 3 through 10 are answered "Yes," please list all applicable conditions and details in Section E on page 6 of this application.

3 Have any of the persons proposed for insurance ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? **Yes** **No** **Yes** **No**

4 Are any of the persons proposed for insurance currently:
(a) bedridden or confined to any hospital, nursing home, or other medical facility?
(b) using any of the following: walker, wheelchair, electric scooter, oxygen or catheter?

Section D

Underwriting Information – continued

	Proposed Insured		Other Proposed Insured	
	Yes	No	Yes	No
5 In the past 6 months , have any of the persons 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) received, or been advised to have, any of the following: care in a nursing home, assisted living facility, or adult day care facility; or home health care services, or physical, occupational or speech therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 In the past 10 years , have any of the persons 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) been or are currently a member of Alcoholics Anonymous or Narcotics Anonymous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Have any of the persons proposed for insurance ever (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek care or treatment for, or (c) consulted with a health care provider 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) any disease of the lungs or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) any brain, nerve or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) any disease or disorder of vision or hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid or other glandular/metabolic disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 If female, is the person proposed for insurance currently pregnant or has the person proposed for insurance ever had complications of pregnancy? If currently pregnant, approximate delivery date _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 In the past 12 months , have any of the persons proposed for insurance lost more than 10 pounds? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 In the past 10 years , have any of the persons proposed for insurance:				
(a) had any illness, injury, surgery, hospitalization, medical examination or care not listed in Section E?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) had or received treatment for any unexplained fever, weight loss, fatigue or chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) been advised by a physician to have a surgical operation or procedure otherwise not listed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Have any of the persons proposed for insurance: (If answered “Yes,” please list details in Section I)				
(a) ever been declined, postponed, limited, denied reinstatement or asked to pay extra premium by any insurance company?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section D

Underwriting Information – continued

(b) engaged in any hazardous sports or activities such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, skydiving, skin diving or scuba diving, cliff diving, base jumping, or bungee jumping within the last three years, or plan such activity in the next two years?	Proposed Insured		Other Proposed Insured	
	Yes	No	Yes	No
(If “Yes,” complete the appropriate questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) any intention of traveling or living outside the USA or Canada in the next two years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(If “Yes,” complete Foreign Travel Questionnaire.)				
(d) flown as a civilian pilot, student pilot or crew member within the last three years, or plan such activity in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(If “Yes,” complete Aviation Questionnaire.)				
(e) within the last 5 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? . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) within the last 10 years, been convicted of a felony?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) been on probation within the last 12 months or are currently on probation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12 Do any of the persons proposed for insurance currently have a personal physician?

(If “Yes,” to question 12, please list details below.)

Person Proposed for Insurance	Name, address and telephone number of personal physician	Date last seen	State reason, findings and treatment

13 In the past 5 years, have any of the persons proposed for insurance consulted with a doctor or been hospitalized or treated for any other health condition?

(If “Yes,” to question 13, please list details below.)

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

14 In the past 2 years, have any of the persons proposed for insurance, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication?

(If “Yes,” to question 14, please list details below. If more space is needed, use Section I.)

Person Proposed for Insurance	Medication Name (Copy From Pharmacy Label)	Date (last taken)	Prescribing Physician (if any)	Reason	Dosage / Frequency

Section D

Underwriting Information – continued

15 Family History – Please list details below for both Proposed Insured and Other Proposed Insured (if applicable).

	Age if Living		Age at Death		If Living, Present Health; If Deceased, Cause of Death	
	Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured
Father						
Mother						
Sibling 1						
Sibling 2						
Sibling 3						
Sibling 4						

Section E

Additional Details and Explanations – Proposed Insured & Other Proposed Insured

(Use Section I for any explanation where space is insufficient)

Ques. No.	Person Proposed for Insurance	Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation is performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

Section F

Personal Finances

1 What is the purpose of this insurance? (i.e., Income Replacement, Mortgage Protection, Key Person, Buy-Sell):

2 If applying for \$500,000 or more, complete Personal Finances for each person proposed for insurance.

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

3. Has any person proposed for insurance ever filed for bankruptcy? Yes No
 If "Yes," please provide type(s) and date(s): _____

Section G

Other Coverage and Replacement Information

- 1 Have you or the Insured been offered cash or any other consideration for obtaining this policy? Yes No
- 2 Are you planning to enter into a finance arrangement to pay any premium payments due under this policy? . . . Yes No
If "Yes," to questions 1 or 2, provide information in Section I.
- 3 List below all life insurance policies and/or annuity contracts on any of the Proposed Insureds 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 or within an unconditional refund period.) If none, check the following box. None
- 4 Have any of the Proposed Insureds had, or do they intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? Yes No
If "Yes," to question 4, complete the appropriate box(es) below.

The Producer shall comply with any additional state and/or Company replacement requirements.

Company	Proposed Insured	Policy or Contract Number	Face Amount	Pending? <input type="checkbox"/> Yes <input type="checkbox"/> No	ADB Amount	1035 Exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No	To Be Replaced or Converted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Assigned or Sold? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Sold
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section H

Beneficiary Information

NOTE: The beneficiary for an Additional Insured Rider or Other Insured Rider will be the Primary Insured unless you designate otherwise in this Section H of this application.

Proposed Insured

	Name	Relationship	% Share	Social Security #
Primary Beneficiary				
Primary Beneficiary				
Contingent Beneficiary				
Contingent Beneficiary				

Other Proposed Insured

	Name	Relationship	% Share	Social Security #
Primary Beneficiary				
Primary Beneficiary				
Contingent Beneficiary				
Contingent Beneficiary				

Proposed Insured

Plan of Insurance _____

Amount of Life Insurance Applied For:

\$ _____

Tobacco Status: Tobacco Nontobacco

Risk/Rate Class Applied For:

Best Available (Risk Class Proposed _____)

[Universal Life]

[Death Benefit Options:]

[Option 1: (Level) Accumulation Value Included in Specified Amount]

[Option 2: (Increasing) Accumulation Value in Addition to Specified Amount]

Other Proposed Insured

Do not complete for Additional Insured Rider or Other Insured Rider

Plan of Insurance _____

Amount of Life Insurance Applied For:

\$ _____

Tobacco Status: Tobacco Nontobacco

Risk/Rate Class Applied For:

Best Available (Risk Class Proposed _____)

[Universal Life]

[Death Benefit Options:]

[Option 1: (Level) Accumulation Value Included in Specified Amount]

[Option 2: (Increasing) Accumulation Value in Addition to Specified Amount]

Optional Riders: (Not all riders are available with all products or in all states)

- [Disability Rider]
- [Accidental Death Benefit Rider \$ _____]
- [Guaranteed Insurability Rider \$ _____]
- [Dependent Children's Rider _____ Units]
- [Additional Insured Rider]
 - [Proposed Insured \$ _____]
 - [Spouse \$ _____]
 - [Other \$ _____]
 - [(Please Specify _____)]

- [Disability Rider]
- [Accidental Death Benefit Rider \$ _____]
- [Guaranteed Insurability Rider \$ _____]
- [Dependent Children's Rider _____ Units]
- [Additional Insured Rider]
 - [Proposed Insured \$ _____]
 - [Spouse \$ _____]
 - [Other \$ _____]
 - [(Please Specify _____)]

[TERM LIFE]

Optional Riders: (Not all riders are available with all products or in all states)

- [Waiver of Premium Rider]
- [Accidental Death Benefit Rider \$ _____]
- [Dependent Children's Rider _____ Units]
- [Other Insured Rider \$ _____]

- [Waiver of Premium Rider]
- [Accidental Death Benefit Rider \$ _____]
- [Dependent Children's Rider _____ Units]
- [Other Insured Rider \$ _____]

Section K

Dependent Children's Rider (Complete only if Children are proposed for insurance)

The beneficiary for the Dependent Children's Rider will be the Proposed Insured or as otherwise set forth in the rider. If more space is needed to provide Dependent Children information, attach separate sheet if necessary.

Dependent Children Underwriting Information

Have any of the Dependent Children proposed for insurance received medical care for or had:

- (a) a heart or circulatory disease? Yes No (b) a birth defect or mental abnormality? Yes No
- (c) juvenile diabetes or any form of cancer? Yes No
- (d) any other chronic illness or condition which requires periodic medical care within the past 3 years? Yes No

NOTE: Provide details for "Yes" answers. Please include child's name and illness or condition. (Use additional sheet if necessary.)

1 Child #1 _____
First Name Initial Last Name

Age _____ Male Female Birth Date _____
MM DD YY

Social Security Number _____ Relationship to Proposed Insured _____

2 Child #2 _____
First Name Initial Last Name

Age _____ Male Female Birth Date _____
MM DD YY

Social Security Number _____ Relationship to Proposed Insured _____

3 Child #3 _____
First Name Initial Last Name

Age _____ Male Female Birth Date _____
MM DD YY

Social Security Number _____ Relationship to Proposed Insured _____

4 Child #4 _____
First Name Initial Last Name

Age _____ Male Female Birth Date _____
MM DD YY

Social Security Number _____ Relationship to Proposed Insured _____

Section L

Premium and Billing Information

Proposed Insured		Other Proposed Insured	
1	Amount collected \$ _____	1	Amount collected \$ _____
2	Modal Premium \$ _____	2	Modal Premium \$ _____

(To the Producer: In order to collect money, the Premium Acceptance Guidelines and other requirements for a Temporary Life Insurance Agreement must be satisfied.)

3 Mode of Payment: Annual Semiannual Quarterly Monthly Bank Service Plan PRD

4 **Complete only for PRD or Association:** Full Name of Group/Organization: _____
Date Joined: _____ / _____

AUTHORIZATION TO RECEIVE INFORMATION FROM AND DISCLOSE INFORMATION TO THE MIB GROUP, INC. (“MIB”):

The MIB Group, Inc. (“MIB”) is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

“Personal Information” means information about me, including health information such as medical history, mental and physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claim information.

To the MIB: I authorize you to disclose Personal Information about me to United of Omaha Life Insurance Company, its representatives and its reinsurers. You are not authorized to disclose Personal Information about me to a consumer reporting agency. The Personal Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance.

I also authorize United of Omaha Life Insurance Company and its reinsurers to disclose Personal Information about me to the MIB. I understand that the 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 submit a claim for benefits.

Unless revoked earlier, this authorization will remain in force for 24 months from the date below. A copy of this authorization is as effective as the original.

AGREEMENT:

Each of the undersigned, including the Producer(s), certify that we have read the completed application. I, the undersigned, understand and agree that:

- 1 All answers in this application are true and complete and will be relied on by United of Omaha to determine insurability. 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, by signing this Life Insurance application, I/We authorize premiums due to be automatically paid to United of Omaha, by electronic fund transfer. I/We understand and agree that these authorized withdrawals for premium payments will continue until this authorization is cancelled in writing.
- 3 In order for United of Omaha to issue a policy as a result of this application: **(1)** all persons proposed for insurance must complete all required examinations and tests (medical, paramedical, laboratory), **(2)** United of Omaha must receive the reports from all required examinations and tests, and any other information (such as an Attending Physician’s Statement) that it requires, and **(3)** the application must be approved for issue by United of Omaha’s Underwriting Department. If **(1)**, **(2)** or **(3)** is not met, no policy will be issued and no coverage will be provided except by a **Temporary Insurance Agreement and Receipt**, if provided.
- 4 If the first full initial premium is paid on the date of the completed application and I am eligible for the insurance policy applied for in accordance with the underwriting standards of United of Omaha on the date the application is approved by United of Omaha’s Underwriting Department, the issue date of the policy will be the date shown in the policy. The coverage under the policy will be effective on the issue date.
- 5 If **(1)** the full initial premium **(a)** is not collected at the time this application is completed, or **(b)** will be paid by electronic funds transfer from my designated bank account after this application is approved for issue, or **(2)** the issued policy is different than the policy applied for, then 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)** there has been no 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 the execution and delivery of a good health statement and delivery receipt by the insured(s) and policyowner(s), if required) are completed and accepted during the lifetime of the proposed insured(s). The full initial premium will provide coverage from the date coverage is effective until the date the next premium is due under the policy. 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.
- 6 The person proposed for insurance, or the Applicant if applicable, will immediately notify United of Omaha of any change in that person’s health or habits that will change any statement or answer to any question in the application. **If the person proposed for insurance is not eligible for the insurance applied for, I agree that no policy of any kind will be in effect except for coverage provided under the terms of the Temporary Insurance Agreement and Receipt, if issued.**
- 7 If, prior to policy delivery, any person proposed for insurance dies, or there has been a change in the health or habits of the person(s) proposed for insurance, the producer cannot deliver the policy and must return it to United of Omaha’s home office.
- 8 In no event will benefits be paid for the same loss under both a **Temporary Insurance Agreement and Receipt**, and any policy issued from this application.
- 9 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.
- 10 If the Applicant is other than the person proposed for insurance, the Applicant will own the policy.

– continued on next page –

- 11 No Producer can: **(a)** waive or change any Receipt or policy provision; or **(b)** agree to issue a policy.
- 12 **Fraud Warning:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGNATURE(S):

I have read and understand the Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. (“MIB”), the Agreement Section and the Temporary Insurance Agreement and Receipt, if provided, and I approve all my answers as recorded in this application.

Signed at: _____ Date _____
City State MM DD YY

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)

PRODUCER STATEMENT:

- 1 In addition to the above 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/have replaced, or will replace, any existing life insurance policies or annuity contracts? Yes No
If “Yes,” the Producer shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.
- 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? Yes No
If “No,” explain. _____
- 4 In the presence of each person proposed for insurance, have you, the Producer(s), asked each question exactly as written and recorded the answers completely and accurately? Yes No
If “No,” explain. _____

Signature of Producer #1

Production Number Date

Signature of Producer #2

Production Number Date

Print or Stamp Producer #1 Name

Print or Stamp Producer #2 Name

Agency Name

Agency Stamp

SERFF Tracking Number: MUTM-125727010 *State:* Arkansas
Filing Company: United of Omaha Life Insurance Company *State Tracking Number:* 39567
Company Tracking Number: AMY PEITZ
TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: Individual Life Application - C497LNA08A
Project Name/Number: New Fixed Life Application /C497LNA08A

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MUTM-125727010 State: Arkansas
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 39567
Company Tracking Number: AMY PEITZ
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life Application - C497LNA08A
Project Name/Number: New Fixed Life Application /C497LNA08A

Supporting Document Schedules

Review Status:
Satisfied -Name: Certification/Notice 07/09/2008
Comments:
Attachment:
AR Read Cert.pdf

Review Status:
Satisfied -Name: AR Fee Schedule Cert 07/09/2008
Comments:
Attachment:
AR Fee Schedule Cert .pdf

Review Status:
Satisfied -Name: Attachment A - 8445L-0603 Red- 07/09/2008
lined
Comments:
Attachment:
8445L-0603 red-lined.pdf

CERTIFICATION

This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

	<u>Form</u>	<u>Description</u>	<u>Score</u>
	C497LNA08A	Application for Life Insurance	40*

* When scored together with the policy the form meets or exceeds the state flesch score requirement.

United of Omaha Life Insurance Company

Date: July 9, 2008



Daniel J. Kennelly
Vice President and Chief Compliance Officer

ARKANSAS
INSURANCE
DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: United of Omaha Life Insurance Company

Company NAIC Code: 261-69868

Company Contact Person & Phone: Amy Peitz

402-351-2449

INSURANCE DEPARTMENT USE ONLY:

ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LIFE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.

* _____ X \$50 = \$ _____

**Retaliatory \$ _____

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.

* _____ X \$50 = _____

**Retaliatory \$ _____

Life and/or Disability Policy, Contract or Annuity Forms : Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.

* 1 X \$20 = \$20.00

**Retaliatory \$ _____

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.

* _____ X \$25 = \$ _____

**Retaliatory \$ _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority

* _____ X \$400 = _____

Filing to amend Certificate of Authority.

*** _____ X \$100 = _____

***THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

****THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

*****THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SEC. 23-61-401.**

Life Insurance Application

Administration Use Only



United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

ADULT LIFE
 JUVENILE LIFE

New Business
 Replacement/
Conversion

Addition to Existing
Policy Number _____

Section A Proposed Primary Insured

- 1 Proposed Primary Insured: _____ Social Security Number: _____ - _____ - _____
- 2 Legal Residence Address: _____
- 3 Mailing Address ~~for Premium Notices:~~ _____
- 4 E-mail Address: _____
- 5 Home Phone Number: (____) _____ Best Time to Call: _____
~~Cell~~ Phone Number: (____) _____ Business Phone Number: (____) _____
- 6 Are you and all persons proposed for insurance a citizen(s) of the United States? Yes No If "No," include a photocopy of the permanent residency Visa for each Proposed Insured.
- 7 Sex: Male Female Date of Birth: ____/____/____ Age: _____ Birthplace (state): _____
- 8 Height: _____ Weight: _____
- 9 Driver's License Number: _____ State of Issue: _____
- 10 Occupation: _____ Duties: _____
- 11 Name of Firm or Employer: _____ Business Phone Number: (____) _____
- 12 Current Annual Income: \$ _____
- 13 Owner's Name (If different from Proposed Primary Insured or if Proposed Primary Insured is under Age 15): _____
- 14 Owner's Address: _____
Street No., Apt. No. City, State ZIP
- 15 Owner's Relationship to Proposed Primary Insured: _____ Social Security No. (or Taxpayer ID No.): _____
- 16 Owner's Primary Phone Number: (____) _____

Are you a citizen of the United States? (If "No," list details below.) _____ Yes No

Documentation	Date of Arrival in the United States
<input type="checkbox"/> Permanent Resident Card (card number _____)	
<input type="checkbox"/> Visa (specify type _____)	____/____/____

Section B ~~Spouse/Child(ren)~~ New Fixed Life app section C covers the children information and Section B covers other proposed

Complete Only If Spouse/Child(ren) Are Proposed For Insurance. (Child must be 18 years or younger at time of application.)

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

Spouse's Birthplace (state): _____

Spouse's Occupation: _____ Spouse's Current Annual Income: \$ _____

Spouse's Driver's License Number: _____ State of Issue: _____

Spouse's E-mail Address: _____

Do all family members proposed for insurance live with the Proposed Primary Insured? Yes No If "No," explain and give name, address and phone number where family member can be contacted. _____

Section C

Plan Information

Plan of Insurance: _____ Face Amount: \$ _____

Death Benefit Options: Option 1: Accumulation Value Included in Specified Amount
(Universal Life Only) Option 2: Accumulation Value In Addition to Specified Amount

Riders: Amounts

- Waiver of Premium or Disability
- Accidental Death Benefit _____
- Additional Insured Rider (Primary Insured) _____

The beneficiary of the Accidental Death Benefit Rider and the Additional Insured Rider on the Primary Insured will be the Beneficiary named in this application or named in a later endorsement to the policy.

- Dependent** Children's Rider _____ (Units)
- Spouse Rider _____
- Additional Insured Rider (Spouse) _____
- Other **Insured Rider** (Please Specify) _____

Amount of Life Insurance Applied For: \$ _____

- [Disability Rider]
- [Guaranteed Insurability Rider \$ _____]
- [**Proposed Insured \$ _____**]

Tobacco Status: Tobacco Nontobacco
 Risk/Rate Class Applied For:
 Best Available (Risk Class Proposed _____)

(This information is located in Section H of the new fixed life app) The beneficiary for (1) an Additional Insured Rider on the Spouse, or (2) an Additional Insured Rider on a person other than the Primary Insured, will be the Primary Insured unless you designate otherwise in Section I of this application.

Premium:

Amount Collected: \$ _____ **(To the Producer: In order to collect money, the Premium Acceptance Guidelines and other requirements for a Temporary Life Insurance Agreement must be satisfied).**

Planned Modal Premium: \$ _____

Method of Payment: **Monthly** Bank Service Plan Quarterly Semiannual Annual PRD

Complete only for PRD or Association or Franchise Coverage:

Full Name of Group/Organization: _____ Date Joined: _____

Beneficiary Information:

Primary Beneficiary: _____ Relationship: _____

~~Address: _____~~

~~SSN/TIN: _____ DOB: _____~~

Contingent Beneficiary: _____ Relationship: _____

Address: _____

~~SSN/TIN: _____ DOB: _____~~

~~Unless otherwise specified, payments will be shared equally by all Primary Beneficiaries who survive the Proposed Primary Insured, if none, by all Contingent Beneficiaries who survive. The right to change the beneficiary is reserved unless otherwise stated.~~

If more space is needed to provide Beneficiary Information, please use Section I.

Section D Other Coverage and Replacement Information

- 1 Have you or the Insured been offered cash or any other consideration for obtaining this policy?..... Yes No
- 2 Are you planning to enter into a finance arrangement to pay any premium payments due under this policy?. Yes No
If "Yes," to questions 1 or 2, provide information in Section I.
- 1 List below all life insurance policies and/or annuity contracts on any Proposed Insured(s) that are now in force, now pending, or that have terminated in the last 13 months. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt, or within an unconditional refund period). If none, check the following box: None
- 2 Have you had, or do you intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, subjected to borrowing, or otherwise discontinued because of this application? Yes No If "Yes," check the appropriate box(es) below. The Producer shall comply with any additional state and/or Company replacement requirements.

Company	Proposed Insured	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Section E Underwriting Information – Proposed Primary Insured

Please Print. All Questions Relate to the Proposed Primary Insured.

- 1 Name, address and telephone number of personal physician of the Proposed Primary Insured: _____
(a) Date last seen: _____ (b) State reason, findings and treatment: _____
- 2 Name, address and telephone number of any other physician consulted in the last 5 years by the Proposed Primary Insured: _____
(a) Date: _____ (b) State reason, findings and treatment: _____

IF QUESTIONS 3 THROUGH 7 ARE ANSWERED "YES," PLEASE LIST ALL APPLICABLE CONDITIONS AND LIST DETAILS IN SECTION F.

- 3 Have you **ever** (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek care or treatment for, or (c) consulted with a health care provider regarding:

	Yes	No
(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/ministroke?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Any disease of the lungs or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
(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?	<input type="checkbox"/>	<input type="checkbox"/>
(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?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Any brain, nerve or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>
(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?	<input type="checkbox"/>	<input type="checkbox"/>
(g) Any disease or disorder of vision or hearing?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Cancer, tumor, blood/bleeding disorder, diabetes, thyroid or other glandular/metabolic disorder?	<input type="checkbox"/>	<input type="checkbox"/>
- 4 Have you **ever** been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? Yes No
- 5 During the **last 10 years**, have you:

(a) had any illness, injury, surgery, hospitalization, medical examination or care not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
(b) had or received treatment for any unexplained fever, weight loss, fatigue or chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>
(c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test?	<input type="checkbox"/>	<input type="checkbox"/>
(d) been advised by a physician to have a surgical operation or procedure otherwise not listed?	<input type="checkbox"/>	<input type="checkbox"/>
- 6 If female, is the person proposed for insurance currently pregnant or has the person proposed for insurance ever had complications of pregnancy? ~~Are you pregnant?~~..... Yes No
Enter approximate delivery date: _____
~~Any complications with this pregnancy or previous pregnancies?~~ Yes No
- 7 During the **last 12 months**, have you lost more than 10 pounds? Yes No

8 During the **last 2 years**, have you, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication?

(If "Yes," to question 8 (a), (b) or (c), please list details below.) If more space is needed, use Section I.

Medication Name (Copy From Pharmacy Label)	Date (last taken)	Prescribing Physician (if any)	Reason	Dosage / Frequency

Section E Underwriting Information — Proposed Primary Insured (continued)

9 During the **last 10 years**, have you: (If answered "Yes" please list details in Section F)

(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**

(b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? ...

(c) been or are you currently a member of Alcoholics Anonymous or Narcotics Anonymous?

10 ~~During the last 10 years~~, have you used:

(a) any form of tobacco?

(b) any form of nicotine replacement therapy (for example — nicotine gum, patch, or spray?)

If you answered "Yes" in 10 (a) or (b), please provide details below.

Form of Tobacco/Nicotine Replacement Therapy	Number Per Day	Date Stopped

11 Have you: (If answered "Yes" please list details in Section I). **Yes** **No**

(a) ever been declined, postponed, limited, denied reinstatement or asked to pay an extra premium by any insurance company?

(b) engaged in any hazardous sports or activities such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, skydiving, skin diving or scuba diving, **cliff diving, base jumping, or bungee jumping** within the last three years, or plan such activity in the next ~~six months~~ **next two years**? ..

(c) any intention of traveling or living outside the USA or Canada in the next two years?

(If "Yes," complete Foreign Travel Questionnaire.)

(d) flown as a civilian pilot, student pilot or crew member within the last three years, or plan such activity in the next 12 months? (If "Yes," complete Aviation Questionnaire.)

(e) within the last 5 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?

(f) been convicted of a felony within the last 10 years?

(g) been on probation within the last 12 months or are you currently on probation?

(h) applied for, or are you currently receiving disability, hospital or medical benefits of any kind from any insurance company, government, employer or other source?

12 Please complete: **added columns for Proposed Insured and Other Proposed Insured**

Family History	Age if Living	If Living, Present Health	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Siblings				

Section F Additional Details and Explanations — Proposed Primary Insured

(Use Section I for any explanation where space is insufficient)

Ques. No.	Medical Impairment, Condition, Injury, illness or Results of Testing or Examinations Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician
8445L-0603			-4-		LA8445

Section G

Underwriting Information – Spouse/Child(ren)

Please Print. All Questions Relate to Spouse and/or Child(ren) who is/are proposed for insurance.

1 Name, address and telephone number of personal physician of the Spouse/Child(ren): _____

(a) Date last seen: _____ (b) State reason, findings and treatment: _____

2 Name, address and telephone number of any other physician consulted in the last 5 years by the Spouse/Child(ren): _____

(a) Date: _____ (b) State reason, findings and treatment: _____

IF QUESTIONS 3 THROUGH 7 ARE ANSWERED “YES,” PLEASE LIST ALL APPLICABLE CONDITIONS AND LIST DETAILS IN SECTION H.

3	Has the Spouse/Child(ren) ever (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek care or treatment for, or (c) consulted with a health care provider regarding:	Spouse	Child(ren)
		Yes	No
		Yes	No
	(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/ministroke?	<input type="checkbox"/>	<input type="checkbox"/>
	(b) Any disease of the lungs or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
	(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?	<input type="checkbox"/>	<input type="checkbox"/>
	(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?	<input type="checkbox"/>	<input type="checkbox"/>
	(e) Any brain, nerve or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>
	(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?	<input type="checkbox"/>	<input type="checkbox"/>
	(g) Any disease or disorder of vision or hearing?	<input type="checkbox"/>	<input type="checkbox"/>
	(h) Cancer, tumor, blood/bleeding disorder, diabetes, thyroid or other glandular/metabolic disorder?..	<input type="checkbox"/>	<input type="checkbox"/>
4	Has the Spouse/Child(ren) ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
5	During the last 10 years , has the Spouse/Child(ren):		
	(a) had any illness, injury, surgery, hospitalization, medical examination or care not listed above? ...	<input type="checkbox"/>	<input type="checkbox"/>
	(b) had or received treatment for any unexplained fever, weight loss, fatigue or chronic cough?	<input type="checkbox"/>	<input type="checkbox"/>
	(c) had any X-rays, electrocardiograms, blood or other studies, except for an HIV test?.....	<input type="checkbox"/>	<input type="checkbox"/>
	(d) been advised by a physician to have a surgical operation or procedure otherwise not listed?.....	<input type="checkbox"/>	<input type="checkbox"/>
6	Is spouse/child(ren) pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
	Enter approximate delivery date: _____		
	Any complications with this pregnancy or previous pregnancies?	<input type="checkbox"/>	<input type="checkbox"/>
7	During the last 12 months has the Spouse/Child(ren) lost more than 10 pounds?	<input type="checkbox"/>	<input type="checkbox"/>
8	During the last 2 years , has the Spouse/Child(ren), (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication?	<input type="checkbox"/>	<input type="checkbox"/>

(If “Yes,” to question 8 (a), (b) or (c), please list details below.) If more space is needed, use Section I.

Person Proposed for Insurance	Medication Name (Copy From Pharmacy Label)	Date (last taken)	Prescribing Physician (if any)	Reason	Dosage / Frequency

Section G Underwriting Information — Spouse/Child(ren) (continued)

- 9** During the **last 10 years**, has the Spouse/Child(ren):
(If you answered “Yes” please list details in Section H)
- | | | | |
|---|--------------------------|--------------------------|---|
| | Spouse | | Child(ren) |
| | Yes | No | Yes No |
| (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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (c) been or are you currently a member of Alcoholics Anonymous or Narcotics Anonymous? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
- 10** During the **last 10 years** has the Spouse/Child(ren) proposed for insurance used:
- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| (a) any form of tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) any form of nicotine replacement therapy (for example — nicotine gum, patch, or spray?) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- If you answered “Yes” in 10 (a) or (b), please provide details below.**

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

- 11 Has the Spouse/Child(ren) proposed for insurance:**
(If answered “Yes,” please list details in Section I)
- | | | | |
|--|--------------------------|--------------------------|---|
| | Spouse | | Child(ren) |
| | Yes | No | Yes No |
| (a) ever been declined, postponed, limited, denied reinstatement or asked to pay an extra premium by any insurance company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (b) engaged in any hazardous sports or activities such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, hang gliding, skydiving, skin diving or scuba diving within the last three years, or plan such activity in the next six months?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (c) any intention of traveling or living outside the USA or Canada in the next two years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| <i>(If “Yes,” complete Foreign Travel Questionnaire.)</i> | | | |
| (d) flown as a civilian pilot, student pilot or crew member within the last three years, or plan such activity in the next 12 months? (If “Yes,” complete Aviation Questionnaire.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (e) within the last 5 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (f) been convicted of a felony within the last 10 years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (g) been on probation within the last 12 months or are you currently on probation?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| (h) applied for, or are you currently receiving disability, hospital or medical benefits of any kind from any insurance company, government, employer or other source?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

12 Complete for Spouse:

Family History	Age if Living	If Living, Present Health	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Siblings				

Section H Additional Details and Explanations — Spouse/Child(ren)

(Use Section I for any explanation where space is insufficient)

Ques. No.	Name	Condition, Injury, Symptom of Ill Health or Findings of Examination (If operation is performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

Each of the undersigned, including the undersigned Producer(s), certify that they have read the completed application and agree to the following:

I, the undersigned, understand and agree that:

- 1 All answers in this application are true and complete and will be relied on by United of Omaha to determine insurability. 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, by signing this Life Insurance application, I/We authorize premiums due to be automatically paid to United of Omaha, by electronic fund transfer. I/We understand and agree that these authorized withdrawals for premium payments will continue until this authorization is cancelled in writing.
- 2 In order for United of Omaha to issue a policy as a result of this application: (a) all persons Proposed ~~Insureds~~ for insurance must complete all required examinations and tests (medical, paramedical, laboratory), (b) United of Omaha must receive the reports from all required examinations and tests, and any other information (such as an Attending Physician's Statement) that it requires and, (c) the application must be approved for issue by United of Omaha's Underwriting Department. If (a), (b) or (c) is not met, no policy will be issued and no coverage will be provided except by a Temporary Insurance Agreement and Receipt, if provided.
- 4 If the first full initial premium is paid on the date of the completed application and I am eligible for the insurance policy applied for in accordance with the underwriting standards of United of Omaha on the date the application is approved by United of Omaha's Underwriting Department, the issue date of the policy will be the date shown in the policy. The coverage under the policy will be effective on the issue date.
- 5 If (1) the full initial premium (a) is not collected at the time this application is completed, or (b) will be paid by electronic funds transfer from my designated bank account after this application is approved for issue, or (2) the issued policy is different than the policy applied for, then 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) there has been no 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 the execution and delivery of a good health statement and delivery receipt by the insured(s) and policyowner(s), if required) are completed and accepted during the lifetime of the proposed insured(s). The full initial premium will provide coverage from the date coverage is effective until the date the next premium is due under the policy. 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.
- ~~3 In order for the policy to go into effect, (a) all policy delivery requirements must be completed and accepted by the Proposed Insured and Policyowner, and (b) there must be no change in either the health or habits of any Proposed Insured that would change the answers to any questions on the application prior to: (i) the date the application is approved for policy issued, or, if later (ii) the date the full initial premium is paid. The Proposed Insured or Applicant, Owner/Trustee shall immediately notify United of Omaha's Underwriting Department of any change in health or habits of any Proposed Insured that will change any statement or any answer to any question in the application. If the person proposed for insurance is not eligible for the insurance applied for, I agree that no policy of any kind will be in effect except for coverage provided under the terms of the Temporary Insurance Agreement and Receipt, if issued.~~
- 4 If, prior to policy delivery, any Proposed Insured dies, or there has been a change in the health or habits of ~~any Proposed Insured~~, the person(s) proposed for insurance, the Producer cannot deliver the policy and must return it to United of Omaha's home office.
- 5 In no event will benefits be paid for the same loss under both a Temporary Insurance Agreement and Receipt and any policy issued from this application.
- 6 I have received the MIB Group, Inc. Pre-Notice, a Fair Credit Reporting Act Disclosure Statement, a Notice of Information Practices, an Investigative Consumer Reports Notice, a Summary of Rights Under the Fair Credit Reporting Act, and a Life Insurance Buyer's Guide before completing this application.
- 7 If the Applicant is other than the ~~person proposed for insurance Proposed Primary Insured~~, the Applicant will own the policy.
- 8 No producer can waive or change any Receipt or policy provision or agree to issue a policy.
- 9 Any Person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I have read and understand the Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. ("MIB"), the Agreement Section and the Temporary Insurance Agreement and Receipt, if provided, and I approve all my answers as recorded in this application.

~~I have read and understand this Agreement Section and any Receipt provided, and I approve all my answers as recorded in this application.~~

Signed at: _____ Date _____
 City State

Signature of Proposed Primary Insured (Age 15 and Over)

Signature of Spouse (if a Proposed Insured)

Signature of Parent or Guardian (if Proposed Insured under age 15)

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))

- 10** In addition to the above Agreement, has the Proposed Insured informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? Yes No
- 11** Do you, the Producer(s), know or have reason to believe that the policy applied for has replaced or will replace any existing life insurance policy(ies) and/or annuity contract(s)? Yes No If "Yes," the Producer shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.
- 12** Did you, the Producer(s), give the Proposed Primary Insured the MIB Group, Inc. Pre-Notice, the Fair Credit Reporting Act Disclosure Statement, the Notice of Information Practices, the Investigative Consumer Reports Notice, the Summary of Rights Under the Fair Credit Reporting Act and the Life Insurance Buyer's Guide? Yes No (If "No," explain.) _____
- 13** In the presence of the Proposed Primary Insured/Spouse have you asked each question exactly as written and recorded the answers completely and accurately? Yes No (If "No," explain.) _____

Signature of Producer

Date

Print or Stamp Producer Name

Signature of Producer

Date

Print or Stamp Producer Name