Filing at a Glance

Company: United Home Life Insurance Company

Product Name: 200-536 4-09
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form

SERFF Tr Num: UFFL-126139486
SERFF Status: Closed-Approved-Closed
Co Tr Num: 200-536 4-09
Author: Karen Hynes
Date Submitted: 05/18/2009

State: Arkansas
State Tr Num: 42416
State Status: Approved-Closed
Reviewer(s): Linda Bird
Disposition Date: 05/20/2009
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
Implementation Date:
State Filing Description:

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 05/20/2009

Deemer Date:
Submitted By: Karen Hynes
Filing Description:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filed concurrently with Indiana, our state of domicile.
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 05/20/2009
Created By: Karen Hynes
Corresponding Filing Tracking Number:

Attached please find the forms noted below for your review and approval.

Form 200-536A 4-09 (AR) is our Provider Whole Life Insurance Application that will be used to apply for a product currently on file with your department and those products that may be filed at a later date. This form is new and replaces form 200-536A 8-07 (AR) approved by your department September 28, 2007. The main differences between the form enclosed and that previously approved are we: a) updated the proposed insured's replacement question; b) updated Medical Information Bureau references to MIB, Inc.; c) revised the street address and added the website address of MIB, Inc. in the Fair Credit Reporting Act/MIB, Inc., Notice; and d) added language regarding anti-money laundering.

Form 200-541A 4-09 (AR) is our Provider Whole Life Insurance Tele-Application – Part I that will be used to apply for a product currently on file with your department and those products that may be filed at a later date. This application is used in conjunction with form 200-542A 8-07 (AR), Provider Whole Life Insurance Tele-Application - Part II, previously approved by your department September 28, 2007.

Form 200-541A 4-09 (AR) is new and replaces form 200-541A 8-07 (AR) approved by your department September 28, 2007. The main differences between the form enclosed and that previously approved are we: a) updated the proposed insured's replacement question; b) updated Medical Information Bureau references to MIB, Inc.; c) revised the street address and added the website address of MIB, Inc. in the Fair Credit Reporting Act/MIB, Inc., Notice; and d) added language regarding anti-money laundering.

We hereby certify we are in compliance with Ark. Code Ann. 23-79-138 and Regulation 49 and this submission meets the provisions of Rule 19.

We reserve the right to make any typographical corrections or make minor revisions to the appearance of the forms due to printing constraints.

If you have any questions or need any additional information, please feel free to contact me at 317-692-7465 or by email at Karen.Hynes@infarmbureau.com.

Company and Contact

Filing Contact Information

Karen Hynes, karen.hynes@infarmbureau.com
225 S East 317-692-7465 [Phone]
Indianapolis, IN 46202

Filing Company Information

United Home Life Insurance Company	CoCode: 69922	State of Domicile: Indiana
225 S. East St.	Group Code:	Company Type: LAH
Indianapolis, IN 46202	Group Name:	State ID Number:
(317) 692-7465 ext. [Phone]	FEIN Number: 35-0841899	

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00

SERFF Tracking Number:	*UFFL-126139486*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*42416*
Company Tracking Number:	*200-536 4-09*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-536 4-09*		
Project Name/Number:	*/*		

Retaliatory?	No
Fee Explanation:	AR imposes a filing fee of $20 per application.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Home Life Insurance Company	$40.00	05/18/2009	27944965

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/20/2009	05/20/2009

Disposition

Disposition Date: 05/20/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UFFL-126139486*	*State:*	*Arkansas*
Filing Company:	*United Home Life Insurance Company*	*State Tracking Number:*	*42416*
Company Tracking Number:	*200-536 4-09*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*200-536 4-09*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Provider Whole Life Insurance Application		Yes
Form	Provider Whole Life Insurance Tele-Application – Part I		Yes

Form Schedule

Lead Form Number: 200-536A 4-09 (AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	200-536A 4-09 (AR)	Application/ Enrollment Form	Provider Whole Life Insurance Application	Initial		49.700	200-536ar.pdf
	200-541A 4-09 (AR)	Application/ Enrollment Form	Provider Whole Life Insurance Tele-Application – Part I	Initial		47.000	200-541ar.pdf

Provider Whole Life Insurance Application

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

1. Last Name	First Name	Middle Initial	Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female

Marital Status	Height	Weight	Social Security Number	Drivers License No. _____ State _____	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:* _____

Street Address	City	State	Zip Code	Phone Number ( )

2. Employer/Occupation/Duties/How Long There	2.a. How many hours worked per week?

3. Beneficiary Name (for the Face Amount listed in 6.b.) a. Primary	Relationship	Age
b. Contingent	Relationship	Age

4.a. Owner Name	Relationship	Social Security Number

Owner Street Address	City	State	Zip Code

4.b. Contingent Owner Name	Relationship	Social Security Number

5. Billing Street Address	City	State	Zip Code

Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code

6.a. Plan of Insurance: Provider

6.b. Face Amount: $_____

If this face amount is $25,000 or greater, the Company will issue the policy with a face amount 1% higher at no additional charge. The corresponding increase in death benefit will be paid to the Charitable Gift Beneficiary you designate below.

6.c. If the Face Amount shown above is $25,000 or greater:

1. List the Charitable Gift Beneficiary
   Name _____ Address _____
   (If none chosen, Charitable Gift Beneficiary will be American Red Cross.)
2. The following benefits will be attached to the policy: Life Threatening Cancer Accelerated Benefit Rider and Common Carrier Accidental Death Benefit Rider.

6.d. If the issue age of the proposed insured is 17 years or less, the following benefit will be attached to the policy: Guaranteed Insurability Benefit Rider.	6.e. Waiver of Premium ❑	6.f. Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Qtrly. ❑ PAC Modal Premium Amount $

7. Will this insurance replace or change any other insurance policies or annuities? ❑ Yes ❑ No If "Yes," please complete any necessary replacement forms.

8. Name of physician last consulted and name of family physician if different: (Required)
   Physician _____ Date _____
   Address _____ Phone No. ( ) _____
   Reason, Diagnosis and/or Treatment _____
   Family Physician _____

9. Have you: a. used nicotine in any form in the past 12 months? If yes, indicate type ❑ cigarettes ❑ cigars ❑ pipe ❑ chewing ❑ snuff ❑ other _____ (nicotine replacement products)	❑ Yes ❑ No
b. Used nicotine in any form in the past and quit? If yes, date last used? _____	❑ Yes ❑ No
10. In the past 10 years have you had or been diagnosed or treated for any disease or disorder of: a. throat, nose, lungs or respiratory system such as tuberculosis, shortness of breath, asthma, bronchitis, chronic obstructive pulmonary disease, emphysema, or sleep apnea?	❑ Yes ❑ No
b. heart, circulatory, cerebrovascular system such as high or low blood pressure, chest pain, heart attack, coronary artery disease, congestive heart failure, heart murmur, stroke, TIA (Transient Ischemic Attack), peripheral vascular disease, anemia, Sickle Cell Anemia?	❑ Yes ❑ No

10. (continued)

c. digestive system (stomach, intestines, rectum, liver, pancreas, gallbladder) such as ulcer, colitis, Crohn's disease, hepatitis B & C, cirrhosis or pancreatitis?	❑ Yes ❑ No
d. brain, nervous system, paralysis, convulsions, seizures, epilepsy or mental disorders such as depression, anxiety, Schizophrenia, Bipolar disorder, suicide attempt, eating disorder, multiple sclerosis, Alzheimer's disease, or dementia?	❑ Yes ❑ No
e. kidney, urinary, bladder, reproductive, breast or prostate disorders such as kidney disease, stone, colic, stricture, sexually transmitted disease?	❑ Yes ❑ No
f. muscles, bones, joints, skin such as arthritis, rheumatoid arthritis, fractures, back problems, lupus, ALS-Lou Gehrig's Disease?	❑ Yes ❑ No
g. cancer, tumor or polyps, melanoma or other malignancy?	❑ Yes ❑ No
h. endocrine system such as diabetes, thyroid disorder, goiter?	❑ Yes ❑ No
i. eyes or ears such as impaired sight or hearing?	❑ Yes ❑ No
j. AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex) or AIDS related conditions or any other immune disorders?	❑ Yes ❑ No
11. Have you:	
a. had a chronic cough, significant weight change (more than 10 lbs. other than normal growth for children), chronic fatigue, diarrhea or enlarged glands within the past two years?	❑ Yes ❑ No
b. had an electrocardiogram, x-ray, blood test, urinalysis or any other diagnostic tests within the past 5 years?	❑ Yes ❑ No
c. tested positive for antibodies to the AIDS (Human T-cell Lymphtropic Type III HTL V-II) virus within the past ten years?	❑ Yes ❑ No
d. consulted a medical practitioner or received hospital or sanitarium care in the past 5 years other than listed in Section 8?	❑ Yes ❑ No
e. been declined, postponed, limited or had a policy issued other than as applied for on any life, health or disability insurance or reinstatement thereof in the past 5 years?	❑ Yes ❑ No
f. had surgical procedure, been advised to have or contemplated any surgical procedure, operation or organ transplant within the past ten years?	❑ Yes ❑ No
g. been rejected, deferred or discharged by the armed forces for a physical or mental condition?	❑ Yes ❑ No
h. used (other than prescribed by a physician) narcotics, LSD, cocaine, amphetamines, barbiturates or marijuana; or been dependent upon or excessively used, alcohol, drugs or narcotics (whether prescribed by a physician or not); or been treated, or been advised to seek treatment or counseling for alcohol or drug usage; or been arrested or awaiting trial for DUI or substance violation?	❑ Yes ❑ No
i. had a driver's license revoked or suspended or ever been arrested or convicted for other than a misdemeanor; or had in the past two years two or more moving violations or two or more vehicle accidents?	❑ Yes ❑ No
j. engaged in or contemplated engaging in sky diving, racing, any other hazardous sport or any type of flying as a pilot or crew member in the past five years?	❑ Yes ❑ No
k. applied for or received any kind of benefits, pension or disability for any injury, sickness or impaired condition in the past five years?	❑ Yes ❑ No
l. had any application for any other life, health or disability income insurance now pending or contemplated with this company or any other company?	❑ Yes ❑ No
12. Are you:	
a. currently taking any medications? (indicate type and dosage in Section 14)	❑ Yes ❑ No
b. currently pregnant, if female? (If yes, include due date _____)	❑ Yes ❑ No
c. now under the observation of a medical practitioner or receiving any kind of medical treatment?	❑ Yes ❑ No
d. aware of any symptoms for which you have not yet consulted a medical practitioner?	❑ Yes ❑ No
13. Do your parents or siblings now have or had in the past: cancer, heart or kidney disease or any other hereditary disease prior to age 60? If yes, give details below.	❑ Yes ❑ No

Relationship	Age if living	Age at Death	Health Condition	Cause of Death

14. Details of "Yes" answers to any Questions:

Dates	Name and Address of Physician	Diagnosis	Treatment

I hereby apply for the insurance indicated above and I am submitting the first premium. I certify that the answers are true and accurate whether written by my own hand or not. I understand that my Policy will not be effective until the date it is issued by the Company.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

$_____ paid with application.

☐ I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount.

Dated _____ , this _____ day of _____ , _____
City State Month Year

X _____ X _____
Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

To the best of my knowledge and belief the insurance applied for herein is ☐ is not ☐ intended to replace or change any existing life insurance or annuity coverage.

☐ I certify that I have provided the proposed insured a copy of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration.

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail _____

Agent: Phone # _____ Fax# _____ License Identification Number (____) _____
State

Please select one:

Underwriting Information:

☐ Standard (Juvenile Age 0-17)

☐ Standard Tobacco

☐ Standard Non tobacco

☐ Preferred Non tobacco

Check or money order must accompany. All premium checks must be made payable to United Home Life Insurance Company. Do not make check or money order payable to the agent or leave the Payee blank. Include copy of voided check for bank draft.

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

Please select ONLY one option, complete bank information and sign authorization below.

☐ Draft my account for the first premium (initial premium may be drafted upon receipt of this application). Please draft subsequent premiums on the _____ day of each month.

☐ Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day each month.
Month, Day

☐ Do NOT draft my account for the first premium. The initial premium is attached, is being mailed or will be collected on delivery. Please draft subsequent premiums on the _____ day of each month.

I understand that my policy will not be effective until the date it is issued by the Company.

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

TO: _____ Bank _____Bank Address

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry.

I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account No._____ Date_____ Bank signature of Premium Payor _____

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application, please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

I understand that my policy will not be effective until the date it is issued by the company.

RECEIPT

Received from _____ The sum of $ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance $_____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____ , _____
Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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 office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life 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.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Terminal Illness Accelerated Benefit Disclosure Statement

Benefits paid under this benefit may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit.

Description of Benefits - This Benefit provides you with the right to access the Death Benefit (discounted at interest for one year)* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

Effect on the Policy - When the accelerated benefit is paid, the policy terminates.

Example - This example is for illustration only, uses a $100,000 policy and an interest rate of 7%.* **The amounts shown are not based on your specific policy.**

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Death Benefit	$100,000.00
Less 7%	6,542.06
Accelerated Benefit	**$ 93,457.94**

*The interest rate used to discount this benefit is defined in Section A of your Terminal Illness Accelerated Benefit Rider.

Provider Whole Life Insurance Tele-Application – Part I

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

1. Last Name	First Name	Middle Initial	Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female

Marital Status	Height	Weight	Social Security Number	Drivers License No. _____ State _____	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:* _____

Street Address	City	State	Zip Code	Phone Number ( )

2. Employer/Occupation/Duties/How Long There	2.a. How many hours worked per week?

3. Beneficiary Name (for the Face Amount listed in 6.b.)	Relationship	Age
a. Primary		
b. Contingent	Relationship	Age

4.a. Owner Name	Relationship	Social Security Number

Owner Street Address	City	State	Zip Code

4.b. Contingent Owner Name	Relationship	Social Security Number

5. Billing Street Address	City	State	Zip Code

Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code

6.a. Plan of Insurance: Provider

6.b. Face Amount: $_____

If this face amount is $25,000 or greater, the Company will issue the policy with a face amount 1% higher at no additional charge. The corresponding increase in death benefit will be paid to the Charitable Gift Beneficiary you designate below.

6.c. If the Face Amount shown above is $25,000 or greater:

1. List the Charitable Gift Beneficiary
   Name _____ Address _____
   (If none chosen, Charitable Gift Beneficiary will be American Red Cross.)
2. The following benefits will be attached to the policy: Life Threatening Cancer Accelerated Benefit Rider and Common Carrier Accidental Death Benefit Rider.

6.d. If the issue age of the proposed insured is 17 years or less, the following benefit will be attached to the policy: Guaranteed Insurability Benefit Rider.	6.e. Waiver of Premium ❑	6.f. Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Qtrly. ❑ PAC Modal Premium Amount $

7. Will this insurance replace or change any other insurance policies or annuities? ❑ Yes ❑ No If "Yes," please complete any necessary replacement forms.

8. Have you:
   a. used nicotine in any form in the past 12 months? ❑ Yes ❑ No
      If yes, indicate type: ❑ cigarettes ❑ cigar ❑ pipe ❑ chewing ❑ snuff ❑ other _____ nicotine replacement products
   b. used nicotine in any form in the past and quit? ❑ Yes ❑ No If yes, date last used? _____

.

I hereby apply for the insurance indicated above and I am submitting the first premium. I certify that the answers are true and accurate whether written by my own hand or not. I understand that my policy will not be effective until the date it is issued by the Company.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

$_____ paid with application.

I understand that Part II Medical Questionnaire is a part of the application when signed by the Proposed Insured(s).

☐ I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount.

Dated _____ , this _____ day of _____ , _____
City State Month Year

X _____ X _____
Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

To the best of my knowledge and belief the insurance applied for herein is ☐ is not ☐ intended to replace or change any existing life insurance or annuity coverage.

☐ I certify that I have provided the proposed insured a copy of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration.

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail _____

Agent: Phone # _____ Fax# _____ License Identification Number (____)_____
State

Please select one:

Underwriting Information:

☐ Standard (Juvenile Age 0-17)

☐ Standard Tobacco

☐ Standard Non tobacco

☐ Preferred Non tobacco

Check or money order must accompany. All premium checks must be made payable to United Home Life Insurance Company. Do not make check or money order payable to the agent or leave the Payee blank. Include copy of voided check for bank draft.

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

Please select ONLY one option, complete bank information and sign authorization below.

☐ Draft my account for the first premium (initial premium may be drafted upon receipt of this application). Please draft subsequent premiums on the _____ day of each month.

☐ Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day each month.
Month, Day

☐ Do NOT draft my account for the first premium. The initial premium is attached, is being mailed or will be collected on delivery. Please draft subsequent premiums on the _____ day of each month.

I understand that my policy will not be effective until the date it is issued by the Company.

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

TO: _____ Bank _____Bank Address

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry.

I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account No._____ Date_____ Bank signature of Premium Payor _____

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application, please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

I understand that my policy will not be effective until the date it is issued by the company.

RECEIPT

Received from _____ The sum of $ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance $_____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____ , _____
Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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 office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life 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.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Terminal Illness Accelerated Benefit Disclosure Statement

Benefits paid under this benefit may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit.

Description of Benefits - This Benefit provides you with the right to access the Death Benefit (discounted at interest for one year)* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

Effect on the Policy - When the accelerated benefit is paid, the policy terminates.

Example - This example is for illustration only, uses a $100,000 policy and an interest rate of 7%.* **The amounts shown are not based on your specific policy.**

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Death Benefit	$100,000.00
Less 7%	6,542.06
Accelerated Benefit	**$ 93,457.94**

*The interest rate used to discount this benefit is defined in Section A of your Terminal Illness Accelerated Benefit Rider.

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Readability - Signed.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: N/A - Applications are being submitted for review.

Comments:

225 South East Street • P.O. Box 7192 • Indianapolis, IN 46207-7192

CERTIFICATION

I hereby certify the following scores on the Flesch Reading Ease Test.

Form 200-536A 4-09	Score 49.7
Form 200-541A 4-09	Score 47.0

Date: 5/18/09

Carl L. Shepherd
Senior Vice President
United Home Life Insurance Company

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