Filing at a Glance

Company: United Heritage Life Insurance Company

Product Name: Universal Life Application
TOI: L09I Individual Life - Flexible Premium Adjustable Life
Sub-TOI: L09I.001 Single Life
Filing Type: Form

SERFF Tr Num: HERT-126217975
SERFF Status: Closed-Approved-Closed
Co Tr Num: UL-3001A-07-2009

Author: Michele MacKenzie
Date Submitted: 07/09/2009

State: Arkansas
State Tr Num: 42895

State Status: Approved-Closed
Reviewer(s): Linda Bird
Disposition Date: 07/22/2009
Disposition Status: Approved-Closed

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

General Information

Project Name: UL-3001A-07-2009
Project Number: UL-3001A-07-2009
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 07/22/2009

Deemer Date:
Submitted By: Michele MacKenzie
Filing Description:
Gentlemen;

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 07/08/2009
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 07/22/2009
Created By: Michele MacKenzie
Corresponding Filing Tracking Number:

This filing is to present United Heritage's new Universal Life Insurance Application. Upon approval, this form will replace Form No. 30-01A (3/2003) filed and approved with the Department on April 03,2003.

This application will be used with our new Marquee Universal Life Products, Forms No(s). 1560 (07-2008) and 1561 (07-2008) filed and approved with the Arkansas Department October 22, 2008.

This is an extensive revision of the prior document, providing producers an instruction page, an “agent’s” statement and a conditional receipt. We have also expanded our requirements for the replacement information and the required disclosures. Form blocks are large to accommodate the information required and the font is made larger for reading ease.

Should you have any questions or concerns regarding this filing, please do not hesitate to contact us. We feel that this document meets all the regulatory requirements of the state of Arkansas.

Company and Contact

Filing Contact Information

Michele MacKenzie, Regulatory Compliance Analyst
mmackenzie@unitedheritage.com
707 W. United Heritage Court
208-475-0981 [Phone] 2281 [Ext]
Meridian, ID 83680

Filing Company Information

United Heritage Life Insurance Company	CoCode: 63983	State of Domicile: Idaho
PO BOX 7777	Group Code: 2878	Company Type:
Meridian, ID 83680-7777	Group Name:	State ID Number:
(208) 475-0981 ext. [Phone]	FEIN Number: 82-0123320	

Filing Fees

Fee Required?	Yes
Fee Amount:	$0.00
Retaliatory?	No
Fee Explanation:	1 Non-Policy Form= $20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United Heritage Life Insurance Company	$20.00	07/09/2009	29089597

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/22/2009	07/22/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Application to be used with Additional Policies	Note To Reviewer	Michele MacKenzie	07/10/2009	07/10/2009

Disposition

Disposition Date: 07/22/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HERT-126217975*	*State:*	*Arkansas*
Filing Company:	*United Heritage Life Insurance Company*	*State Tracking Number:*	*42895*
Company Tracking Number:	*UL-3001A-07-2009*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Universal Life Application*		
Project Name/Number:	*UL-3001A-07-2009/UL-3001A-07-2009*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Supporting Document	Certification of Compliance		Yes
Form	Universal Life Insurance Application		Yes

Note To Reviewer

Created By:

Michele MacKenzie on 07/10/2009 11:36 AM

Last Edited By:

Linda Bird

Submitted On:

07/22/2009 09:24 AM

Subject:

Application to be used with Additional Policies

Comments:

Good Morning,

It has been brought to my attention that the company would like to use this filed application with two additional products. The first are our Legacy Level Term policies, Policy Form NO.(s): 1680 (Rev.11/99) and 1680U(Rev.11/99) filed and approved by the Kansas Department October 30, 2002. The second is our Pro Plus, Non-Participating Whole life policies, Policy Form No.(s): 1840.10(11/2002) and 1840U.10(11/2002) filed and approved by the Kansas Department on December 30, 2002.

I apologize for not providing this information in our General Information Tab. Thank you for your assistance,

Michele MacKenzie, Regulatory Compliance Analyst

Form Schedule

Lead Form Number: 30-01A (Rev. 7-2009)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	30-01A (Rev. 7-2009)	Application/ Enrollment Form	Universal Life Insurance Application	Initial		40.000	30-01A (Rev. 7-2009).pdf

LIFE INSURANCE APPLICATION

United Heritage Life Insurance Company • P.O. Box 7777 • Meridian, ID 83680-7777 • 800-657-6351 • unitedheritage.com

30-01A (Rev. 7-2009)

LIFE INSURANCE APPLICATION INSTRUCTIONS:

Application: Use the appropriate approved application for the state where the owner resides. The application must be signed and dated by the proposed insured/owner and agent. Any correction made on the application must be initialed and dated by the proposed insured/owner. At the top of each page write in the proposed insured's name.

Trial Application: If the proposed insured(s) has an existing serious disease, adverse medical history, a known or suspected insurance hazard or has been previously declined, postponed or rated, please mark the trial application box, submit the application without money and do not order any medical requirements. We will order the proposed insured(s) medical records and after reviewing them inform you on whether we can proceed with the processing of this application.

Tobacco Question: This includes any form of tobacco or nicotine based product. Refer to specific product rate books for details on tobacco usage.

Residence Address: If the owner has more than one residence, provide the address of their legal residence. Provide any pertinent details in the space provided on page 3, under remarks. The owner's legal residence is where they maintain their permanent address and is usually evidenced by what state has issued the applicant a driver's license or other form of state-issued identification.

Total Life Insurance In Force: List all life insurance policies the proposed insured(s) currently has in force. Include the face amount of these policies, the amount of accidental death benefit and whether replacement will occur or is anticipated to occur by this application.

Beneficiaries: Include the first, middle (if applicable) and last name along with the address of each beneficiary and their relationship to the insured. If other than a family member, explain the reason for the beneficiary designation on page 3, under remarks. (If a Trust is the beneficiary, include the name and date of the Trust and provide a copy of the Instrument of Trust.)

Ownership: Complete this section if applicant is other than the proposed insured. Complete all appropriate fields included in this section. If a Trust is the owner, include all the items mentioned above under beneficiaries. If the proposed insured is under age 15, someone other than the proposed insured must own the policy.

Payor: If the payor is someone other than the primary insured or owner of the policy, explain why on page 3, under remarks.

Premium Payments: Submit payor's check with the application. Post dated checks, currency, or personal agent checks will not be accepted. If a **money order** is submitted with an application, a written explanation citing the reasons for using a money order and its amount must be signed and dated by the proposed insured/owner and submitted with the application. If the amount applied for exceeds $500,000, do not collect any money.

Accidental Death Benefit Rider: The maximum amount that can be issued on an individual is $150,000. This includes all amounts in force and applied for in all companies.

Accelerated Benefit Rider: This benefit allows for the payment of a portion of the base policy, not to exceed the lesser of 75% of the face amount or $100,000. This benefit is available only if the insured is diagnosed as terminally ill within a particular time frame set by the state. If requested see ABR rate card and complete ABR application.

Replacement: All states require completion of a state specific replacement form if **replacing** existing life insurance or annuity coverage. Model replacement states must complete a replacement form if they **have** existing life insurance or annuity coverage, regardless of whether a replacement is involved.

Part I section 8: Complete the appropriate questionnaires as requested in section 8. Refer to the agent's website to acquire these forms, if needed.

Part II section 1: Include the name of each proposed insured(s) requesting coverage and complete all questions in this section regarding everyone to be insured by this application.

Signature Requirements (page 5): The Proposed Insured, other insured and owner (if other than proposed insured) must sign the application. If proposed insured is under age 15, a parent or legal guardian must sign the application as the proposed insured. You must provide copies of guardianship papers if applicable.

Agent's Report: It must be completed and submitted with every application. Be sure that you provide the proposed insured(s) with a copy of the **Notice of Disclosure of Information and the Notice to Persons Applying for Insurance.** These two items are on the back side of the HIPAA form.

HIV Consent Form (in states where applicable): This form must be submitted with all applications in which there are blood requirements for the proposed insured(s). These forms are the responsibility of the agent and policies cannot be issued if requirements are not completed.

Preauthorized Check Form: When a preauthorized check plan is used, complete the PC information in its entirety and send to us along with a void check.

HIPAA Form: This form must be filled out and submitted with every application for insurance. One copy must be given to the proposed insured and one must be forwarded to the home office. A HIPAA form must be prepared and appropriately signed for each proposed insured listed on the application.

Conditional Receipt: Do not accept money or issue the Conditional Receipt if any of the medical conditions stated in the receipt apply. If the amount applied for exceeds $500,000, **DO NOT ACCEPT MONEY OR ISSUE THE CONDITIONAL RECEIPT.** (This includes all amounts in force with United Heritage.) If either of the above conditions are not met or, after review of Part I and Part II of the application, the Company is not satisfied that the proposed insured(s) is insurable under the Company's rules for the insurance applied for, we will return the money to the proposed insured/owner with a letter stating the reasons for the return of premium.

PART I
LIFE INSURANCE APPLICATION

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777 ❑ **Trial Application**

1. Proposed Insured's Information

Name (First, Middle, Last) _____

Social Security No. _____ **email** _____

Phone # (_____) **(** ❑ Male ❑ Female **)** **(** ❑ Tobacco ❑ Non-Tobacco **)** **(** ❑ Single ❑ Married **)**

Birthdate _____ **Age** _____ **State/Country of Birth** _____ **(Driver's License** # _____ **State** _____ **)**

Residence Address _____

Mailing Address _____

Occupation _____ **Employer Name** _____

Alternate Phone # _____ **Employer Address** _____

Total Life Insurance in Force (If None, show "None") _____

Company	Face Amount	Acc. Death	Repl. or Change	Year Issued

Primary Beneficiary Name _____ **Relationship** _____

Address _____ **Split %** _____

Primary Beneficiary Name _____ **Relationship** _____

Address _____ **Split %** _____

Contingent Beneficiary Name _____ **Relationship** _____

Address _____ **Split %** _____

Contingent Beneficiary Name _____ **Relationship** _____

Address _____ **Split %** _____

2. Owner - Who shall be the owner of the policy issued? ❑ Proposed Insured ❑ Other Insured ❑ Both Insureds Jointly

Other: Name _____ SS/TIN # _____

Address _____ Relationship to Insured _____

3. Policy Plan _____

Premium Mode ❑ Annual ❑ Semi-Annual

Face Amount $ _____ Premium $ _____ ❑ Monthly P.C. ❑ Other _____

4. ❑ Waiver ❑ Accidental Death Benefit Amt. $ _____ ❑ Accelerated Benefit Rider

(If requested, complete and submit required ABR application form)

Additional Universal Life Benefits:

Planned Premium $ _____ (billing amount)

Death Benefit: ❑ Option A (Level) ❑ Option B (Spec. Amt. + Cash Value)

❑ Level Term Rider _____ Years _____ Face Amt.

❑ Other Insured Spouse (term to age 85) _____ Face Amt.

❑ Other Insured Children (term to age 25) _____ Face Amt.

❑ Other _____

Additional Life Benefits:

❑ Automatic Premium Loan

❑ Children's Term Rider _____ Units

❑ Level Term Rider _____ Years _____ Face Amt.

❑ Premium Deposit Fund _____ Deposit Amt.

❑ Other _____

5. Other Insured's Information

Name (First, Middle, Last) _____

Social Security No. _____ **email** _____

Phone # (_____) **(** ❑ Male ❑ Female **)** **(** ❑ Tobacco ❑ Non-Tobacco **)** **(** ❑ Single ❑ Married **)**

Birthdate _____ **Age** _____ **State/Country of Birth** _____ **(Driver's License #** _____ **State** _____ **)**

Residence Address _____

Mailing Address _____

Occupation _____ **Employer Name** _____

Alternate Phone # _____ **Employer Address** _____

Total Life Insurance in Force (If None, show "None") _____

Company	Face Amount	Acc. Death	Repl. or Change	Year Issued

Primary Beneficiary Name _____ **Relationship** _____

Address _____ **Split %** _____

Primary Beneficiary Name _____ **Relationship** _____

Address _____ **Split %** _____

Contingent Beneficiary Name _____ **Relationship** _____

Address _____ **Split %** _____

Contingent Beneficiary Name _____ **Relationship** _____

Address _____ **Split %** _____

6. Children to be covered by Riders (Other Insured Children or Children Term Rider)

Child _____ SS# _____ Birthdate _____ Age ___ ❑ M ❑ F

Child _____ SS# _____ Birthdate _____ Age ___ ❑ M ❑ F

Child _____ SS# _____ Birthdate _____ Age ___ ❑ M ❑ F

Child _____ SS# _____ Birthdate _____ Age ___ ❑ M ❑ F

7. Replacement Information

	YES	NO
Do you have any existing life insurance or annuity contracts in force or pending?	❑	❑
Will this policy replace or change any existing life policy or annuity contract?	❑	❑

If yes, list company name and address: _____

_____

For Home Office Use

Proposed Insured's Name_____

8. General Information

The following questions apply to all proposed insureds. Give details to any "yes" answers below.

Has or does any person proposed for insurance:		**YES**	**NO**
a. In the next 2 years, or within the last 2 years flown as a pilot, student pilot, or crew member in any aircraft, including ballooning and ultra-light planes? (If yes, complete aviation questionnaire)	a.	❑	❑
b. In the next 2 years, plan to participate in, or within the last 2 years participated in hang-gliding, base jumping, scuba diving, parachuting, mountain climbing, auto/boat/motorcycle racing, or any other hazardous sport or avocation? (If yes, complete appropriate avocation questionnaire)	b.	❑	❑
c. Had any application for life insurance rated, declined, postponed, modified or renewal refused?	c.	❑	❑
d. In the last 10 years, plead no contest, been convicted of a felony or placed on probation for any reason?	d.	❑	❑
e. In the past 10 years, had any alcohol or drug related convictions?	e.	❑	❑
f. In the past 2 years, traveled/resided or have plans in the next 2 years to travel/reside outside the USA or Canada? (If yes, complete the appropriate travel questionnaire)	f.	❑	❑
g. In the last 3 years, had a driver's license suspended/revoked, had any motor vehicle accidents, or had 2 or more moving violations?	g.	❑	❑
h. Expect to be placed on active duty status in the near future or is currently on active duty in the Armed Forces? (If yes, complete the appropriate military questionnaire)	h.	❑	❑
i. Engage in regular exercise? If yes, give detail below: Type_____ Frequency_____ How Long? (hrs./min.) _____	i.	❑	❑
j. Used any form of tobacco or nicotine based products? (If yes, designate type, quantity and date last used) ❑ Cigarettes ❑ Pipe/Cigar ❑ Chew ❑ Gum ❑ Patch ❑ Other Quantity_____ Date Last Used_____ List insured name _____	j.	❑	❑
k. Citizenship: are you a Citizen of USA? (If no, provide country, type of visa and expiration date) Country _____ Type of Visa _____ Expiration Date _____	k.	❑	❑

Remarks - Identify Question (number and letter) and give details.

_____
_____
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_____
_____

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777

Proposed Insured's Name_____

PART II OF LIFE INSURANCE APPLICATION

This Part II is to be completed with respect to all persons to be covered.

1. Proposed Insured(s)	Height	Weight	Name, Address and Phone Number of Personal Physician	Date of last visit
_____	___ ft.	___ in. ___ lbs.	_____	_____
_____	___ ft.	___ in. ___ lbs.	_____	_____
_____	___ ft.	___ in. ___ lbs.	_____	_____
_____	___ ft.	___ in. ___ lbs.	_____	_____
_____	___ ft.	___ in. ___ lbs.	_____	_____

2. Within the past 5 Years, has any Proposed Insured(s):		YES	NO
a. Consulted with, or been examined or treated by any physician, medical professional or practitioner?	a.	❑	❑
b. Been observed or treated at a clinic, hospital, sanitarium or other medical facility?	b.	❑	❑
c. Had an electrocardiogram, X-Ray, or other diagnostic test?	c.	❑	❑
d. Been medically advised to have any operations, treatments or diagnostic test(s) not yet performed?	d.	❑	❑
e. Used any prescribed medication or drugs?	e.	❑	❑

3. Within the past 10 years, has any Proposed Insured(s) had or been diagnosed by a member of the medical profession as having:		YES	NO
a. High blood pressure, chest pain, heart murmur, heart attack, irregular heart beat, TIA, stroke, rheumatic fever, or any other disorder of the heart or blood vessels?	a.	❑	❑
b. Cancer, leukemia, lymphoma, melanoma, skin cancer, or any other tumor or cyst?	b.	❑	❑
c. Asthma, emphysema, chronic bronchitis, COPD, pneumonia, shortness of breath, spitting of blood or any other disorder of the respiratory system?	c.	❑	❑
d. Diabetes, or any other disorder of the thyroid or endocrine system?	d.	❑	❑
e. Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, intestinal bleeding or any other disorder of the stomach, intestine, liver, pancreas, or gall bladder?	e.	❑	❑
f. Sugar, protein or blood in urine; sexually transmitted disease(s); kidney stones or any other disorder of kidney, bladder, prostate, breasts or reproductive organs?	f.	❑	❑
g. Dizziness, fainting, seizures, Alzheimer's, dementia, headaches, paralysis, or any other disorder of the brain or nervous system?	g.	❑	❑
h. A nervous or mental disorder, depression or attempted suicide?	h.	❑	❑
i. Anemia, clotting disorder, platelet disorder, or any other disorder of the blood or lymph glands?	i.	❑	❑
j. Arthritis, gout or any disorder of the joints, muscles, bones or spine?	j.	❑	❑
k. Disorder of the eyes, ears, nose, mouth or throat?	k.	❑	❑
l. AIDS (Acquired Immunodeficiency Syndrome), or any other disorders of the immune system?	l.	❑	❑
m. Any physical deformity, defect or amputation?	m.	❑	❑

4. Within the past 10 years, has any Proposed Insured(s):		YES	NO
a. Been medically advised to limit or cease consumption of alcohol or drugs, sought counseling, received treatment or participated in a program for the purpose of limiting or discontinuing the use of alcohol or drugs?	a.	❑	❑
b. Used narcotics, sedatives, amphetamines or barbiturates except as prescribed by a physician and used in the prescribed amounts and dosages?	b.	❑	❑
c. Used any illegal drugs such as heroin, cocaine, methamphetamine, ecstasy or any other illicit drug or controlled substance?	c.	❑	❑

5. Has any Proposed Insured(s):		YES	NO
a. Been diagnosed as currently pregnant? (If yes, what is expected delivery date _____)	a.	❑	❑
b. Had any loss of weight in the past year?	b.	❑	❑
c. Had a parent, brother or sister who had cancer, diabetes, heart or kidney disorder, alcoholism or nervous disorder?	c.	❑	❑

Give details for all "YES" answers, including name of person affected, all dates, diagnoses, durations, outcomes and names and addresses of all attending physicians. Attach additional pages if necessary and have proposed insureds sign and date.

_____

_____

_____

_____

_____

_____

Proposed Insured's Name_____

The laws of **some states** require us to furnish you with the following notice: It is unlawful to knowingly file a claim statement that provides materially false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. The company is required to report suspected fraudulent activity to the Department of Insurance or appropriate regulatory authorities. "Notice to the Following States' Residents, For Your Protection, your state requires its Individual Fraud Notice as follows:"

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona - Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana and New Mexico - 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.

California and Texas - Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of insurance within the department of regulatory agencies.

Hawaii - Law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Ohio - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oregon - 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 may be a crime and may subject such person to criminal and civil penalties.

Tennessee and Washington - It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

DISCLOSURE AND AUTHORIZATION TO OBTAIN INFORMATION

In order to enable United Heritage Life Insurance Company to determine my eligibility for the coverage and benefits of this life insurance application, I authorize any physician, hospital, clinic, practitioner, or other medical or medically related facility, health care provider, insurance or reinsurance company, insurance support organization, the Medical Information Bureau, Inc. (MIB), consumer reporting agency, motor vehicle agency or employer to disclose any and all information, records or knowledge that you have about me and my minor children's physical and mental condition to United Heritage Life Insurance Company. This authorization covers medical history, tests, diagnosis, treatment or prognosis, and includes information about drugs, alcoholism, Human Immunodeficiency Virus, sexually transmitted diseases, and any other non-medical information regarding me or my minor children.

Any information obtained will not be released by United Heritage Life Insurance Company to any person or organization except to reinsurance companies, to MIB, Inc., other insurance companies as designated by me, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or authorized by me.

I know that I may request to receive a copy of this Authorization. I agree that a photocopy of this Authorization will be as valid as the original. I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB, Inc. I agree this Authorization will be valid for 24 months from the date shown below. An investigative consumer report may be prepared in connection with this transaction.

STATEMENT OF AGREEMENT

All statements contained in this application for insurance shall be deemed representations and not warranties. I have read all of the questions and answers in this application and any form(s) made part of this application and declare that they are true and complete to the best of my knowledge and belief and have been correctly recorded. I acknowledge that the Company will rely on such statements and answers in considering this application and that this application shall be a part of any policy issued. I understand that no person other than an officer of the Company is authorized to pass on the acceptability for insurance, to modify or change any contract, or to waive any Company requirement. **I agree this policy shall not take effect until the policy is received by the owner and the first premium is paid in full, provided all Proposed Insured's health and other conditions are as described in this application at time of receipt of the policy.**

"Under penalties of perjury, I certify that the (taxpayer identification) number shown on this form is my correct taxpayer number and that I am not subject to withholding for under reporting under Section 3406(a)(1)(c).

Proposed Insured's Signature (If under age 15, Parent or Guardian must sign)	Date (Month/Day/Year)	City & State Where Signed
Other Insured's Signature	Agent's Signature	
Owner's Signature (If other than proposed insured)	Agent's Number	

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777

Proposed Insured's Name_____

Agent's Report (must always be completed and signed)

1. To the best of your knowledge, is replacement or change of existing insurance involved in this transaction? ..... ❑ Yes ❑ No
2. The death benefit amount was determined by (check all that apply)
   ❑ Insured ❑ Multiple of Income ❑ Cost of Final Expense ❑ Needs Analysis (If so send documentation)
   ❑ Other _____
3. How long have you known Proposed Insured? _____
   a. Is proposed insured related to you or your spouse? ..... ❑ Yes ❑ No
      If yes, explain in Remarks.
4. Financial Status: (If unknown, so state.)
   Average earned monthly income $_____ Other income $_____ per month. Source? _____
5. Are you aware of anything about the health, habits, avocation, environment or mode of life which may affect the insurability of any Proposed Insured(s)? If yes, explain in Remarks. ..... ❑ Yes ❑ No
6. Did you personally see all Proposed Insureds at the time of this application? ..... ❑ Yes ❑ No
   If no, whom did you <u>not</u> see? _____
7. If Proposed Insured is married, show amount of insurance on spouse. $ _____
8. Purpose of the insurance: ❑ Personal ❑ Family Protection ❑ Estate Protection ❑ Creditor ❑ Business
   ❑ Other (give explanation) _____
9. To your knowledge, does the Owner intend to change ownership of this policy after its issuance? (ie. To a trust, viatical or life settlement company or other person) ..... ❑ Yes ❑ No
10. If Proposed Insured is a minor dependent child: (Explain any No answers below in remarks.)
    a. Did you see the child? ..... ❑ Yes ❑ No
    b. Are all brothers and sisters insured for equal amounts? ..... ❑ Yes ❑ No
    c. Are parents insured for at least as much as that applied for on the child? ..... ❑ Yes ❑ No
    d. Occupation of supporting parent _____
    e. Annual income of supporting parents _____
11. If Business Insurance, indicate type:
    a. ❑ Key Person ❑ Sole Proprietor ❑ Partnership ❑ Corporate ❑ Buy-Sell ❑ Other _____
    b. If Proposed Insured is an Officer or Partner in Business, are all remaining officers or partners applying for insurance at this time? If no explain in Remarks. ..... ❑ Yes ❑ No
12. Underwriting Information:
    Application is submitted: ❑ Paramedical ❑ Non-Medical
    Date of Exam_____ By: Company Name_____
    Also ordered: ❑ EKG ❑ Blood Chemistry Profile ❑ Urine Specimen

Remarks:
_____
_____
_____
_____
_____
_____
_____

I hereby certify that I personally solicited and completed this application; that I have no knowledge of anything which might affect the insurability of any person proposed for insurance which is not fully recorded in this application.

The applicant has been given the "HIPAA Authorization", "Notice of Disclosure of Information", and the "Notice to Persons Applying for Insurance".

Writing Agent's Signature _____ Agent # _____ Share _____

Second Agent _____ Agent # _____ Share _____

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777

Proposed Insured's Name_____

AUTHORIZATION TO DRAW CHECKS ON MY ACCOUNT AND REQUEST FOR PRE-AUTHORIZATION CHECK PLAN

To: United Heritage Life Insurance Company

Name of Policyholder	Policy Number	Payment	Payment Date (PLEASE CHECK ONE)
			❑ 4TH ❑ 10TH ❑ 18TH ❑ 25TH

❑ Draft 1st Month's Premium ❑ Checking (Attach Void Check or Copy of Check) ❑ Savings (Transit/Routing and Account # Required)

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED HERITAGE LIFE INSURANCE COMPANY

TO: THE BANK NAMED BELOW For my benefit and convenience, I hereby request and authorize you to pay and charge to my account any checks, drafts, orders or debit entries drawn or initiated by the UNITED HERITAGE LIFE INSURANCE COMPANY to its own order. This authorization will 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 check, draft, order or debit entry. In consideration of your compliance with such request and authorization, I agree that your treatment of any check, draft, order or debit entry, and your rights in respect to it, shall be the same as if it were signed or initiated personally by me and that if any such check, draft, order or 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 could result in the forfeiture of insurance.

_____ _____

DATE BANK SIGNATURE(S) OF DEPOSITOR(S)

ATTENTION: We have been authorized to withdraw premiums on pre-authorized checks payable to United Heritage Life Insurance Company. A **sample check** has been obtained **for the purpose of correctly positioning the MICR symbols and numbers**, therefore a specification sheet will not be needed. Thank you for your cooperation.

PARTICULARS OF BANK ACCOUNT TO BE CHARGED

(TYPE OR PRINT)

Checking _____ **Savings** _____

Account number: _____ **Routing number:** _____

Name(s) on bank account: _____

TO: BANK _____

ADDRESS _____

CITY, STATE _____

IMPORTANT: 1. COMPLETE ENTIRE FORM. LIST ALL POLICY NUMBERS INVOLVED.
2. **SEND** ENTIRE FORM TO HOME OFFICE WITH **A VOIDED BLANK CHECK**.
3. PLEASE TYPE OR PRINT FULL BANK ADDRESS.

Tape voided check here.
(Do Not Staple)

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777

Proposed Insured's Name_____

Authorization for Release of Health-Related Information to United Heritage Life Insurance Company
This authorization complies with the HIPAA Privacy Rule

_____ _____/_____/_____
Name of proposed insured/patient (please print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United Heritage Life Insurance Company (UHLIC) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that United Heritage Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Heritage Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to **United Heritage Life Insurance Company at P.O. Box 7777, Meridian, Idaho, 83680-7777**, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that United Heritage Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality or health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Heritage Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Proposed Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

HIPAA AUTHORIZATION
1st Copy to Home Office / 2nd Copy to the Insured

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777

Proposed Insured's Name_____

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential. United Heritage Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the 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.

United Heritage Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE TO PERSONS APPLYING FOR INSURANCE

Federal law requires you to be advised that in connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may request to be interviewed in connection with this investigative report.

It is possible that a representative of a firm employed to make such reports may contact you by phone or call on you in person. You have the right to request disclosure of the nature and scope of the investigation. You have the right to have a copy of said report provided to you. You may request a copy in writing to **United Heritage Life Insurance Company at P.O. Box 7777, Meridian, Idaho 83680-7777.**

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777

Proposed Insured's Name_____

UNITED HERITAGE LIFE INSURANCE COMPANY CONDITIONAL RECEIPT

IF WITHIN THE LAST YEAR ANY PROPOSED INSURED HAS RECEIVED TREATMENT OR ADVICE FROM A PHYSICIAN FOR A TUMOR, CANCER, OR BRAIN, HEART, LUNG OR KIDNEY DISORDER, A CONDITIONAL RECEIPT CANNOT BE GIVEN AND PREMIUM MAY NOT BE COLLECTED.

United Heritage Life Insurance Company (UHLIC) has received from_____

❑ A payment of $_____for the insurance applied for with the application.

❑ The authorization for payment of premiums by participation in the Pre-Authorized Check Plan for the insurance applied for is with this application.

This Conditional Receipt does not provide any insurance coverage unless the conditions provided herein are met. Additionally, conditional coverage under this receipt is not in effect if section 1035 exchange paperwork is received without premium payment.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY

TERMS AND CONDITIONS

Conditional Coverage begins: when Part I and Part II of the Application for Insurance are completed and the Company is satisfied that each Insured is insurable under the Company's rules for insurance on the plan. Eligibility is limited to coverage at the class of risk applied for in Part I of the application for insurance. Additionally, a premium must have been accepted and this form completed and signed.

Amount of Coverage: If the Proposed Insured(s) dies while Conditional Coverage is in effect, the Company will pay to the beneficiary named in the Application the lesser of:

(a) The amount of death benefit, if any, which would be payable under the policy and any riders if issued as applied for under the Application for Insurance; or
(b) $100,000 of life insurance if such person is age 15 to 65 and is insurable as a standard class of risk; or
(c) $50,000 of life insurance at all other ages and classes of risk: and
(d) $50,000 of the life insurance for death by accident.

This Conditional Coverage is subject to all limits or exclusions which would be part of the issued coverage. If for any reason, the Company is liable for any coverage as a result of any other pending applications or conditional receipts on the lives of the Propose Insured(s), the Company's total liability shall not exceed the amounts shown in the paragraph above.

General: Premium(s) will be returned if a policy is not delivered and no benefit is paid under this Conditional Receipt. If a policy is delivered, premium(s) will be applied to the first policy premium. No agent can waive or modify this coverage in any way. Premiums are billed from the policy date. If the policy date is prior to the in force date, premiums will be due based on the policy date.

Conditional Coverage ends automatically on the earliest of the following dates:

- The date any policy is offered in connection with a Life Insurance Application; or
- Five days after the date UHLIC mails notice of termination of Conditional Coverage and refunds the advance premium.
- A policy offer resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Company may send a notice or return premium terminating this Conditional Coverage any time before delivery of the policy.

There is no Conditional Coverage if:

- There is material misrepresentation in the answers to any question or statement in the Application for Insurance;
- A Proposed Insured dies by suicide or intentional self-inflicted injury;
- The premium check or authorized withdrawal is not honored.

Dated at _____ X_____
Month Day Year — Signature of Proposed Insured (If under age 15, Parent or Guardian)

X_____ X_____
Signature of Agent — Signature of Other Insured (if applicable)

CONDITIONAL RECEIPT
1st Copy to Home Office / 2nd Copy to the Insured

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

Certification of Readability.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

This filing is to obtain approval for our new Universal Life Insurance Application. The form appears on the form schedule

Item Status: **Status Date:**

Satisfied - Item: Outline of Coverage

Comments:

Not applicable to this filing

Item Status: **Status Date:**

Satisfied - Item: Certification of Compliance

Comments:

Attachment:

Certification of Compliance.pdf

UNITED HERITAGE®
Life Insurance Company
a United Heritage Financial Group Company

July 9, 2009

Arkansas Department of Insurance
Attn. Rates & Forms Divn.
1200 W. 3rd St
Little Rock, AR 72201-1904

CERTIFICATION OF READABILITY

I, Deborah Sloan, Senior V.P. & Chief Actuary, hereby certify that this form, Universal Life Insurance Application Form No. 30-01A (Rev. 7-2009) complies with Arkansas Code §23-80-206 and has a Flesch Readability Score of 40.

Deborah Sloan

Deborah Sloan

Senior Vice President & Actuarial Manager

United Heritage Life Insurance Company
(208) 493-6100 - Toll Free 1-800-657-6351
P.O. Box 7777 - Meridian, Idaho 83680-7777
unitedheritage.com

UNITED HERITAGE®
Life Insurance Company
a United Heritage Financial Group Company

July 9, 2009

Arkansas Department of Insurance
Attn. Rates & Forms Divn.
1200 W. 3rd St
Little Rock, AR 72201-1904

CERTIFICATION OF COMPLIANCE

SERFF FILING# HERT-126217975 UNIVERSAL LIFE APPLICATION
FORM NO. 30-01A (Rev. 7-2009)

I, Geoffrey M. Baker , Vice President. & General Counsel, hereby certify that I have reviewed or supervised the review of the policy forms contained in this filing and hereby certify to the best of my knowledge and belief that they are in compliance with the applicable statutes, regulations and bulletins of the State of Arkansas. I further certify that the forms will be revised and/or discontinued as appropriate in the event of future changes in the statutes, regulations or bulletins.

Geoffrey M. Baker
Vice President & General Counsel

United Heritage Life Insurance Company
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P.O. Box 7777 - Meridian, Idaho 83680-7777
unitedheritage.com