

SERFF Tracking Number: MUTM-126322089 State: Arkansas  
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43629  
Company Tracking Number: WANDA HILL  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 2009 Fixed Life Application - C977LNA09A  
Project Name/Number: 2009 Fixed Life Application/C977LNA09A

## Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: 2009 Fixed Life Application - C977LNA09A SERFF Tr Num: MUTM-126322089 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 43629

Sub-TOI: L08.000 Life - Other

Co Tr Num: WANDA HILL

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Mary Cleasby, Helen Curry, Wanda Hill, Shelly Kaipust, Kim Meyerring, Ellen Cochrane, Kendra Saylor

Disposition Date: 09/30/2009

Date Submitted: 09/29/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: 2009 Fixed Life Application

Project Number: C977LNA09A

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 09/30/2009

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 09/30/2009

Created By: Ellen Cochrane

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Ellen Cochrane

Filing Description:

Please see Cover Letter under the Supporting Documentation Tab.

## Company and Contact

### Filing Contact Information

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Wanda Hill, Senior Policy Drafting and Regulatory Specialist  
 Regulatory Affairs  
 Mutual of Omaha Plaza  
 Omaha, NE 68175  
 wanda.hill@mutualofomaha.com  
 402-351-3440 [Phone]  
 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

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$280.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$280.00	09/29/2009	30922222

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/30/2009	09/30/2009

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Underwater Diving Questionnaire	Ellen Cochrane	09/29/2009	09/29/2009

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## Disposition

Disposition Date: 09/30/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	AR Certificate of Compliance		Yes
Supporting Document	AR Credit Card Cert		Yes
Supporting Document	AR Fee Schedule Cert		Yes
Form	Individual Life Application - Part 1A		Yes
Form	Individual Life Application - Part 1B		Yes
Form	Individual Life Application - Part 2		Yes
Form	Aviation Questionnaire		Yes
Form (revised)	Underwater Diving Questionnaire		Yes
Form	Underwater Diving Questionnaire	Replaced	Yes
Form	Skydiving/Parachuting Questionnaire		Yes
Form	Racing Questionnaire		Yes
Form	Foreign National and Foreign Travel		Yes
Form	Nontobacco Questionnaire		Yes
Form	Rock or Mountain Questionnaire		Yes
Form	Hang Gliding/Base Jumping/Bungee Jumping Questionnaire		Yes
Form	Producer Statement		Yes
Form	Juvenile Life Insurance Supplemental Application		Yes
Form	Childrens Rider Life Insurance Supplemental Application		Yes

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**Amendment Letter**

Submitted Date: 09/29/2009

**Comments:**

Please note we had attached the Aviation questionnaire instead of the Underwater Diving Questionnaire to the Diving Questionnaire. This has now been corrected. Thank you.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
C981LNA09A	Other	Underwater Diving Questionnaire	Initial				0.000	C981LNA09A_Underwater Diving Quest.pdf

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## Form Schedule

### Lead Form Number: C977LNA09A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	C977LNA09A	Application/ Enrollment Form	Individual Life Application - Part 1A	Initial		0.000	C977LNA09A_Indv Life App-Part 1A.pdf
	C978LNA09A	Application/ Enrollment Form	Individual Life Application - Part 1B	Initial		0.000	C978LNA09A_Indv Life App-Part 1B.pdf
	C979LNA09A	Application/ Enrollment Form	Individual Life Application - Part 2	Initial		0.000	C979LNA09A_Indv Life App-Part 2.pdf
	C980LNA09A	Other	Aviation Questionnaire	Initial		0.000	C980LNA09A_Aviation Quest.pdf
	C981LNA09A	Other	Underwater Diving Questionnaire	Initial		0.000	C981LNA09A_Underwater Diving Quest.pdf
	C982LNA09A	Other	Skydiving/Parachuting Questionnaire	Initial		0.000	C982LNA09A_Skydiving.Parachuting Quest.pdf
	C983LNA09A	Other	Racing Questionnaire	Initial		0.000	C983LNA09A_Racing Quest.pdf
	C984LNA09A	Other	Foreign National and Foreign Travel	Initial		0.000	C984LNA09A_Foreign Travel Quest.pdf
	C985LNA09A	Other	Nontobacco	Initial		0.000	C985LNA09A

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9A		Questionnaire				_Nontobacco Quest.pdf
C986LNA0 9A	Other	Rock or Mountain Questionnaire	Initial	0.000		C986LNA09A _Rock or Mountain Quest.pdf
C987LNA0 9A	Other	Hang Gliding/Base Jumping/Bungee Jumping Questionnaire	Initial	0.000		C987LNA09A _Hang Gliding.Base. Bungee Jump Quest.pdf
C997LNA0 9A	Other	Producer Statement	Initial	0.000		C997LNA09A _Producer Statement.pdf
C998LNA0 9A	Application/ Enrollment Form	Juvenile Life Insurance Supplemental Application	Initial	0.000		C998LNA09A _Juvenile Life Ins Supp App.pdf
C999LNA0 9A	Application/ Enrollment Form	Childrens Rider Life Insurance Supplemental Application	Initial	0.000		C999LNA09A _Childrens Rider Supp App .pdf



**PART 1A, PAGE 2 OF 2 LIFE INSURANCE APPLICATION**

**OTHER COVERAGE INFORMATION**

1. Has any person proposed for insurance been offered cash, or any other consideration for obtaining this policy?  Yes  No
2. Are you or any Proposed Insured planning to enter into a finance arrangement to pay any premium payments due under this policy? . . . . .  Yes  No
3. Do you or any person proposed for insurance intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? . . .  Yes  No  
**If "Yes" to questions 1, 2 or 3, provide information in Comments section.**
4. List below all life insurance policies and/or annuity contracts on you, or any Proposed Insured that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt.) If none, check the following box. . . . .  None
5. Has any person proposed for insurance had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? . . . . .  Yes  No

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

Company	Policy or Contract Number	Face Amount	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
					<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	

**COMMENTS**

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

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**RIDER ON OTHER PROPOSED INSURED**

Other Proposed Insured Legal Name \_\_\_\_\_  
 Gender  Male  Female    Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ State of Birth \_\_\_\_\_ Annual Income \_\_\_\_\_  
 Driver's License No \_\_\_\_\_ Driver's License State \_\_\_\_\_  
 Legal Residence Address \_\_\_\_\_  
 Best Time to Call \_\_\_\_\_ Phone No. \_\_\_\_\_ E-mail \_\_\_\_\_

**IF OTHER PROPOSED INSURED IS AGE 0-[17], ALSO COMPLETE JUVENILE SUPPLEMENTAL APPLICATION**

Occupation/Duties \_\_\_\_\_ Employer \_\_\_\_\_

Primary Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth
_____	_____	_____	_____
Contingent Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth
_____	_____	_____	_____

If more space is needed, provide information in Comments section

# UNITED OF OMAHA LIFE INSURANCE COMPANY

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



## PART 1B, PAGE 1 OF 1 LIFE INSURANCE APPLICATION

NON-MEDICAL UNDERWRITING			Proposed Insured	Other Proposed Insured Rider
	1. Are the persons proposed for insurance citizens of the United States? . . . . . <b>If "No," complete the Foreign National questionnaire.</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Has any person proposed for insurance ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy? . . . . . <b>If "Yes," to question 2, please list details below.</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Form of Tobacco/Nicotine Replacement Therapy	Number per Day	Date Stopped
	3. Has any person proposed for insurance <b>If answered "Yes," please list details in the Comments section.</b>			
	(a) had life insurance coverage declined, postponed, or limited, or been denied reinstatement, or asked to pay extra premium by any insurance company? . . . . .		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) engaged in any hazardous sports, or activities within the last three years, 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, or plan such activity in the next two years? . . . . . <b>If "Yes," complete the appropriate questionnaire.</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) any intention of traveling, or living outside the USA, or Canada in the next two years? <b>If "Yes," complete the Foreign Travel questionnaire.</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) flown as a civilian pilot, student pilot, or crew member within the last three years, or plan such activity in the next two years? . . . . . <b>If "Yes," complete the Aviation questionnaire.</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(e) within the last five years (1) been convicted of two or more moving violations, or (2) been convicted of driving under the influence of alcohol, or drugs, or (3) had a driver's license suspended, or revoked? . . . . .		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(f) been convicted of a felony, or have been incarcerated within the last 10 years? . . . . .		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(g) been on probation within the last 12 months, or are currently on probation? . . . . .		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

FINANCES	4. Has any person proposed for insurance ever filed for bankruptcy? . . . . .		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If "Yes," please provide type(s) and date(s) _____					
	5. What is the purpose of this insurance (e.g., income replacement, mortgage protection, key person, buy-sell)? _____					
	6. If applying for \$500,000 or more, complete box(es) below.					
	Person Proposed for Insurance	Total Assets	Total Liabilities	Net Worth	Earned Income	Unearned Income

FAMILY HISTORY	7. Family History – Please list details below for both Proposed Insured and Other Proposed Insured (if applicable).				
		Age at Death	Age at Death	If Living, Present Health – If Deceased, Cause of Death	
		Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured
	Father				
	Mother				
	Sibling 1				
	Sibling 2				
Sibling 3					

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



## PART 2, PAGE 1 OF 3 LIFE INSURANCE APPLICATION

MEDICAL UNDERWRITING	1. Does any person proposed for insurance currently have a personal physician? . . . . .				Proposed Insured <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Proposed Insured Rider <input type="checkbox"/> Yes <input type="checkbox"/> No
	Person Proposed for Insurance	Name, Address and Telephone Number of Personal Physician	Date last seen	State Reason, Findings and Treatment		
	2. Has any person proposed for insurance ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Has any person proposed for insurance ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:					
	(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, or shortness of breath? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(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"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(g) any disease, or disorder of vision, or hearing? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/metabolic disorder? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. In the past 10 years, has any person proposed for insurance						
(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a physician, or other health care provider? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. In the past 12 months, has any person proposed for insurance:						
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity? . . . . .				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



**PART 2, PAGE 3 OF 3 LIFE INSURANCE APPLICATION**

**AGREEMENT**

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

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

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

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

Signed at: \_\_\_\_\_ Date \_\_\_\_\_  
City State Mo Day Yr

\_\_\_\_\_  
Signature of Proposed Insured age 15 and Over

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

\_\_\_\_\_  
Signature of Other Proposed Insured age 15 and Over

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

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

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

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## AVIATION QUESTIONNAIRE

**PLEASE PRINT**

- 1 Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_
- 2 Have you ever flown as a pilot or crew member, or do you intend to do so? \_\_\_\_\_  Yes  No
- 3 What type of license or certificate do you hold?  
Date of issue? \_\_\_\_\_ If expired, give date. Do you intend to renew? \_\_\_\_\_  Yes  No
- 4 Do you intend to qualify for a higher grade certificate?  Yes  No  
If "Yes," when? \_\_\_\_\_
- 5 Do you hold a current FAA medical certificate?  Yes  No  
Date last renewed. \_\_\_\_\_ If expired, do you intend to renew? . . . . .  Yes  No  
When? \_\_\_\_\_

6 Schedule of flying time	Hours as Pilot or Copilot			Hours as Passenger or Crew Member		
	Contemplated Next 12 Months	Past 12 Months	One to Two Years Ago	Contemplated Next 12 Months	Past 12 Months	One to Two Years Ago
COMMERCIAL (flying for pay) Scheduled passenger airline.....						
Employer-owned aircraft for employee transportation.....						
Crop dusting or aerial spraying.....						
Check flying of repaired or production line aircraft.....						
Student instruction.....						
Freight carrying or nonscheduled passenger service, charter or sight-seeing flying.....						
Other (describe below).....						
MILITARY.....						
NONCOMMERCIAL (not flying for pay) Pleasure.....						
Personal business transportation.....						
Instruction as student.....						
Other (describe below).....						

- 7 Total number of hours flown as a pilot.
- 8 Have you flown, or do you intend to fly a prototype, experimental, or home built aircraft? . . . . .  Yes  No
- 9 Do you or have you ever participated in aerobatics, air racing, or stunt flying? . . . . .  Yes  No
- 10 Do you contemplate any type of flying not indicated above? . . . . .  Yes  No  
If "Yes," please explain in **Part 12, "Additional Remarks."**
- 11 Have you ever had an aircraft accident or been grounded, fined or reprimanded for violation  
of air regulations? . . . . .  Yes  No
- 12 **ADDITIONAL REMARKS CLARIFYING ANSWERS TO ABOVE QUESTIONS. Give details of all questions answered "Yes."**  
(Use reverse side of form if necessary.)

\_\_\_\_\_

\_\_\_\_\_

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

\_\_\_\_\_  
Witnessed Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## SKYDIVING/PARACHUTING QUESTIONNAIRE

**PLEASE PRINT – PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER IF NECESSARY**

- 1 Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_
- 2 Do you belong to a club affiliated with the United States Parachute Association? .....  Yes  No  
If "Yes," which affiliation do you hold?  amateur  professional
- 3 Do you follow the regulations and safety standards established by the United States Parachute Association? .....  Yes  No  
If "No," please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 4 How long have you been skydiving/parachuting? \_\_\_\_\_
- 5 Number of jumps:  
(a) Last 12 months \_\_\_\_\_  
(b) One to two years ago \_\_\_\_\_
- 6 Do you take part in exhibitions or competition? .....  Yes  No  
If "Yes," please describe the nature of these events: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 7 Do you receive remuneration for skydiving/parachuting activity? .....  Yes  No  
If "Yes," please provide details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 8 Are you an airplane pilot or do you intend to become one? .....  Yes  No  
If "Yes," please complete Aviation Questionnaire.

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

\_\_\_\_\_  
Witnessed Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## RACING QUESTIONNAIRE

PLEASE PRINT – PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER IF NECESSARY

- 1 Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_
- 2 Do you hold a competition driver's license from any organization? .....  Yes  No  
If "Yes," please list all. \_\_\_\_\_
- 3 Have you ever attended any type of driver's school? .....  Yes  No  
If "Yes," which? \_\_\_\_\_
- 4 How long have you participated in racing? \_\_\_\_\_ Date of last race. \_\_\_\_\_ Where? \_\_\_\_\_
- 5 Over what type of track or course do you race? (e.g., dirt oval, simulated road, off road, etc.) \_\_\_\_\_
- 6 How far do you travel to race? \_\_\_\_\_
- 7 Have you ever competed, or do you intend to compete, outside the U.S.? .....  Yes  No  
If "Yes," where? \_\_\_\_\_
- 8 Do you intend to enter a new class of competition? .....  Yes  No  
If "Yes," please provide details. \_\_\_\_\_
- 9 Have you ever done, or do you intend to do, any stunt driving? .....  Yes  No
- 10 Is racing your full-time occupation? .....  Yes  No
- 11 Do you compete on a traveling circuit? .....  Yes  No  
If "Yes," which? \_\_\_\_\_
- 12 In which racing categories have you participated or plan to participate in the next two years? (Please indicate specific subcategories when applicable)
  - All terrain vehicle**
  - Auto Crash:**  Dive bomber,  Roll over,  T-Bone,  Demolition,  Destruction,  Figure 8,  
 Other (specify) \_\_\_\_\_
  - Drag Racing:**  Top Fuel Dragster,  Top Alcohol Dragster,  Prostock,  Other (specify) \_\_\_\_\_
  - Kart:**  Formula Kart Experimental,  Sprint (mph \_\_\_\_\_),  Enduro (mph \_\_\_\_\_)
  - Midget** (mph \_\_\_\_\_)
  - Off Road:**  Desert (Baja),  Other (specify) \_\_\_\_\_
  - Sports Car:**
    - Formula:**  Formula 1,  Atlantic,  Continental,  Ford,  Vee,  440,  Other (specify) \_\_\_\_\_
    - Grand Touring:**  GT-1,  Trans-Am,  GT-2,  GT-3,  GT-4,  GT-5,  Other (specify) \_\_\_\_\_
    - IMSA GT**
      - Production:**  E,  F,  G,  H,  Other (specify) \_\_\_\_\_
      - Rally:**  Pro Rallying,  Other (specify) \_\_\_\_\_
      - Showroom Stock:**  SSGT,  SSA,  SSB,  SSC,  Other (specify) \_\_\_\_\_
      - Sports Racing:**  ASR,  Can-Am,  CSR,  DSR,  Sports 2000,  Sports Renault  Other (specify) \_\_\_\_\_
      - Sprint Cars:**  USAC Sprint Car,  Other (specify) \_\_\_\_\_
      - Stock Cars (NASCAR/IMSA):**  Nextel Cup,  Winston West,  Busch Grand National,  Modified Division,  
 USAC Super Modified,  Grand American,  All American Challenge,  Charlotte/Daytona Dash,  Late Model,  
 Chargers,  ProFormance/ProStock Sedan,  American Challenge,  Street Stock,  Other (specify) \_\_\_\_\_
    - Other** (specify) \_\_\_\_\_

**13** Name of organization sanctioning races? \_\_\_\_\_  
 Local/regional organization  National organization,  Not sanctioned

**14** Give particulars by types of races, and miles driven in competition, stating "none" where none, as provided below.

Racing Category	Last 12 months			1-2 Years Ago		Contemplated Next 12 months		
	No. of Races	Miles Per Race	Max. Speeds Attained	No. of Races	Miles	No. of Races	Miles	Max. Speeds Expected

**15** \*i.e., NASCAR LATE MODEL STOCK, IHRA FUNNY CAR, IMSA GT-T, STREET STOCK, etc.

<b>16</b> Do you own a competition vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Make and Model	Displacement	Class
Do you have access to any other competition vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Make and Model	Displacement	Class

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

\_\_\_\_\_  
Signature of Proposed/Other Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## FOREIGN NATIONAL AND FOREIGN TRAVEL QUESTIONNAIRE

**TO BE COMPLETED BY PROPOSED INSURED(S) OR POLICYOWNER(S) – PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER IF NECESSARY**

**1** Are you a U.S. citizen? . . . . .  Yes  No  
**(If "Yes," proceed to Question 2.)**

(a) Are you a Permanent Resident (holder of a Permanent Resident Card)? . . . . .  Yes  No

(1) If "Yes," please list your Permanent Resident Card Number: \_\_\_\_\_

(2) If "No," please list the type of visa you hold: \_\_\_\_\_ How long have you lived in the United States? \_\_\_\_\_

(b) Please provide your full name as stated on the Permanent Resident Card or Visa: \_\_\_\_\_  
\_\_\_\_\_

(c) Date of issue on your Permanent Resident Card or Visa: \_\_\_\_\_

(d) Date of expiration on your Permanent Resident Card: \_\_\_\_\_

(e) Country of Birth: \_\_\_\_\_

(f) Do you own a home in the United States? . . . . .  Yes  No

If "Yes," please provide the address: \_\_\_\_\_

(g) Do you own a home in a foreign country? . . . . .  Yes  No

If "Yes," please provide the address: \_\_\_\_\_

(h) If married, does your family live with you in the United States? . . . . .  Yes  No

**2** Are you employed in the United States? . . . . .  Yes  No

(a) If "Yes," please provide the name and address of your employer and describe the duties you perform. \_\_\_\_\_  
\_\_\_\_\_

(b) If "No," please provide source(s) of income while living in the United States. \_\_\_\_\_  
\_\_\_\_\_

**3** Do you plan to travel outside of the United States in the next two years? . . . . .  Yes  No  
**(If "Yes," please answer the following questions below:)**

(a) Where do you plan to travel? \_\_\_\_\_

(b) What is the purpose of travel?  Business  Pleasure

(c) How often? \_\_\_\_\_

(d) Average period of time for each trip: \_\_\_\_\_

(e) What was the date of your last trip? \_\_\_\_\_

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

\_\_\_\_\_  
Signature(s) of Proposed Insured(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature(s) of Policyowner(s)

\_\_\_\_\_  
Date

**Producer Statement:** In the presence of the insured(s) I have asked each question as written and have recorded the answers completely and accurately. If question 1 was answered "No," I have seen the proposed insured(s) or policyowner(s) Permanent Resident Card . . . . .  Yes  No

If "No," please provide explanation. \_\_\_\_\_

\_\_\_\_\_  
Signature(s) of Producer(s)

\_\_\_\_\_  
Date

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## NONTOBACCO QUESTIONNAIRE

Coverage ID: \_\_\_\_\_

This form must be completed for each adult insured – Please attach an additional sheet of paper if necessary

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please Print

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

- 1 Have you used tobacco or nicotine in any form in the past 12 months? .....  Yes  No
- 2 If you ever used tobacco, when did you quit? \_\_\_\_\_
- 3 Within the past three years have you been treated by a health care professional or been told you had:
  - (a) Heart trouble or stroke? .....  Yes  No
  - (b) Cancer or chronic lung disease? .....  Yes  No

Explain any yes answers below. Include dates, diagnosis, duration, treatment and the names and address of all attending physicians.

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I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Insured

**NOTE – You may be contacted by a local paramedical company to provide a urine specimen for nicotine testing. We sincerely appreciate your cooperation if you are contacted.**

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## ROCK OR MOUNTAIN CLIMBING QUESTIONNAIRE

**PLEASE PRINT – PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER IF NECESSARY**

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Are you a member of a club?  Yes  No
2. Type(s) of Climbing: Trail \_\_\_\_\_ Rock \_\_\_\_\_ Snow & Ice \_\_\_\_\_ Mountain \_\_\_\_\_  
Artificial climbing walls \_\_\_\_\_ Other (explain): \_\_\_\_\_  
\_\_\_\_\_
3. Frequency of each: \_\_\_\_\_
4. Date and location of last climb? \_\_\_\_\_  
\_\_\_\_\_
5. How long have you been climbing? \_\_\_\_\_
6. What courses have you completed and in what year(s)? \_\_\_\_\_  
\_\_\_\_\_
7. Do you ever climb without a rope?  Yes  No  
If Yes, please state how often, location and degree of difficulty. \_\_\_\_\_  
\_\_\_\_\_
8. Do you ever climb alone?  Yes  No  
If No, how many other people are normally in your party? \_\_\_\_\_
9. What would their climbing experience typically be? \_\_\_\_\_  
\_\_\_\_\_
10. Are you a lead climber?  Yes  No
11. Name geographical location(s) where you climb, type of climbing, and level (Yosemite Decimal System):  
\_\_\_\_\_  
\_\_\_\_\_
12. Do you plan to go on any overseas expeditions in the next 2 years?  Yes  No  
If Yes, please give full details, including area, length of expedition and frequency of trips. \_\_\_\_\_  
\_\_\_\_\_
13. Time of year you climb: \_\_\_\_\_
14. List the equipment you normally carry: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
15. On your average climb, how many hours/days would you be climbing? \_\_\_\_\_
16. What would your average heights be? \_\_\_\_\_ 17. What would be your level(s) of difficulty? \_\_\_\_\_
18. Maximum height climbed, level and date? \_\_\_\_\_
19. What are your future climbing goals and climbing locations? \_\_\_\_\_  
\_\_\_\_\_

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

This form will not attach to and become part of the policy.

\_\_\_\_\_  
Witnessed Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## HANG GLIDING / BASE JUMPING / BUNGEE JUMPING QUESTIONNAIRE

**PLEASE PRINT – Please attach an additional sheet of paper if necessary**

Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

### HANG GLIDING

1. How many years have you been hang gliding? \_\_\_\_\_
2. How many flights have you made in the past 3 years? \_\_\_\_\_
3. How many flights do you anticipate making in the next 2 years? \_\_\_\_\_
4. Where do you frequently hang glide? \_\_\_\_\_
5. Are you a member of a hang gliding or ultralight club?  Yes  No
6. Are you an amateur or Instructor?  Yes  No
7. Do you participate in hang gliding competitions, events, record attempts or stunts?  Yes  No

### BASE JUMPING

1. How many years have you been base jumping? \_\_\_\_\_
2. How many jumps have you made in the past 3 years? \_\_\_\_\_
3. How many jumps do you anticipate making in the next 2 years? \_\_\_\_\_
4. Where do you frequently jump? \_\_\_\_\_
5. Are you a member of a base jumping club?  Yes  No
6. Do you participate in base jumping competitions, events or stunts?  Yes  No

### BUNGEE JUMPING

1. How many years have you been bungee jumping? \_\_\_\_\_
2. How many jumps have you made in the past 3 years? \_\_\_\_\_
3. How many jumps do you anticipate making in the next 2 years? \_\_\_\_\_
4. Where do you frequently jump? \_\_\_\_\_
5. Are you a member of a bungee jumping club?  Yes  No
6. Do you participate in bungee jumping competitions, events or stunts?  Yes  No

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

This form will not attach to and become part of the policy.

\_\_\_\_\_  
Witnessed Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



# UNITED OF OMAHA LIFE INSURANCE COMPANY

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



## JUVENILE LIFE INSURANCE SUPPLEMENTAL APPLICATION

**PROPOSED INSURED**

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

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



## CHILDREN'S RIDER LIFE INSURANCE SUPPLEMENTAL APPLICATION

**THE BENEFICIARY FOR THE DEPENDENT CHILDREN'S RIDER WILL BE THE PROPOSED INSURED OR AS OTHERWISE SET FORTH IN THE RIDER.**

**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.

**If more space is needed to provide Dependent Children information, attach separate sheet if necessary.**

**DEPENDENT CHILDREN(S) UNDERWRITING INFORMATION**

**1** Child #1 \_\_\_\_\_  
First Name Initial Last Name  
Age \_\_\_\_\_  Male  Female Birth Date \_\_\_\_\_  
Mo Day Yr  
Social Security Number \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

**2** Child #2 \_\_\_\_\_  
First Name Initial Last Name  
Age \_\_\_\_\_  Male  Female Birth Date \_\_\_\_\_  
Mo Day Yr  
Social Security Number \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

**3** Child #3 \_\_\_\_\_  
First Name Initial Last Name  
Age \_\_\_\_\_  Male  Female Birth Date \_\_\_\_\_  
Mo Day Yr  
Social Security Number \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

**4** Child #4 \_\_\_\_\_  
First Name Initial Last Name  
Age \_\_\_\_\_  Male  Female Birth Date \_\_\_\_\_  
Mo Day Yr  
Social Security Number \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_

SERFF Tracking Number: MUTM-126322089 State: Arkansas  
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 43629  
Company Tracking Number: WANDA HILL  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: 2009 Fixed Life Application - C977LNA09A  
Project Name/Number: 2009 Fixed Life Application/C977LNA09A

## Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification  
**Comments:**  
**Attachment:**  
AR Read Cert.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application  
**Comments:**  
The Applications are attached under the Forms Schedule Tab.

**Item Status:** **Status Date:**

**Satisfied - Item:** AR Certificate of Compliance  
**Comments:**  
**Attachment:**  
AR Certif of Compliance with Rule 19.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** AR Credit Card Cert  
**Comments:**  
**Attachment:**  
AR Credit Card Cert.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** AR Fee Schedule Cert  
**Comments:**  
**Attachment:**

*SERFF Tracking Number:* MUTM-126322089      *State:* Arkansas  
*Filing Company:* United of Omaha Life Insurance Company      *State Tracking Number:* 43629  
*Company Tracking Number:* WANDA HILL  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* 2009 Fixed Life Application - C977LNA09A  
*Project Name/Number:* 2009 Fixed Life Application/C977LNA09A  
AR Fee Schedule Cert .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>
C977LNA09A	Life Application Part 1A	*
C978LNA09A	Life Application Part 1B	*
C979LNA09A	Life Application Part 2	*
C980LNA09A	Aviation Questionnaire	*
C981LNA09A	Underwater Diving Questionnaire	*
C982LNA09A	Skydiving/Parachuting Questionnaire	*
C983LNA09A	Racing Questionnaire	*
C984LNA09A	Foreign National and Foreign Travel Questionnaire	*
C985LNA09A	Nontobacco Questionnaire	*
C986LNA09A	Rock or Mountain Climbing Questionnaire	*
C987LNA09A	Hang Gliding/Base Jumping/Bungee Jumping Questionnaire	*
C997LNA09A	Producer Statement	*
C998LNA09A	Juvenile Supplemental Application	*
C999LNA09A	Children's Rider Supplemental Application	*

United of Omaha Life Insurance Company

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\*Meets or exceeds your Flesch score requirement of 40 when scored with the base policy.

Date: September 29, 2009




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Daniel J. Kennelly  
Vice President & Chief Compliance Officer

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: United of Omaha Life Insurance Company

Form Number(s): C977LNA09A,C978LNA09A,C979LNA09A,C980LNA09A,C981LNA09A,  
C982LNA09A,C983LNA09A,C984LNA09A,C985LNA09A,C986LNA09A,  
C987LNA09A,C997LNA09A,C998LNA09A,C999LNA09A

I hereby certify, to the best of my knowledge and belief, that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

  
\_\_\_\_\_  
Signature of Company Officer

Daniel J. Kennelly  
\_\_\_\_\_  
Name

Vice President & Chief Compliance Officer  
\_\_\_\_\_  
Title

September 29, 2009  
\_\_\_\_\_  
Date

# Arkansas Insurance Department

Mike Huckabee  
Governor



Julie Benafield Bowman  
Commissioner

Please read and acknowledge your understanding and assurance of complying with the following requirements:

1. If a sponsor or endorser is involved such as a bank, school, retail store, etc., it must be ascertained whether that sponsor is to receive any form of compensation for the use of the card. If so, this must be disclosed to the insured. If there is compensation, the sponsor would need to be licensed to sell insurance.
2. The company must certify that failure to pay the credit card bill will not affect the premium payment.
3. If the credit card company does not pay the premium for any reason, the insurance company must notify the insured of this and allow a thirty day Grace Period for the insured to pay the premium.

*Daniel Kennedy*  
SIGNATURE

9/29/2009

DATE

United of Omaha Life Insurance Company  
COMPANY

CC-1

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: Wanda Hill

402-351-3440

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.

\* 14 X \$20 = 280.00

\*\*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.**

*SERFF Tracking Number:* MUTM-126322089      *State:* Arkansas  
*Filing Company:* United of Omaha Life Insurance Company      *State Tracking Number:* 43629  
*Company Tracking Number:* WANDA HILL  
*TOI:* L08 Life - Other      *Sub-TOI:* L08.000 Life - Other  
*Product Name:* 2009 Fixed Life Application - C977LNA09A  
*Project Name/Number:* 2009 Fixed Life Application/C977LNA09A

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
09/29/2009	Form	Underwater Diving Questionnaire	09/29/2009	C981LNA09A_Underwater Diving Quest.pdf (Superseded)

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## AVIATION QUESTIONNAIRE

**PLEASE PRINT**

- 1 Name of Proposed Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_
- 2 Have you ever flown as a pilot or crew member, or do you intend to do so? \_\_\_\_\_  Yes  No
- 3 What type of license or certificate do you hold?  
Date of issue? \_\_\_\_\_ If expired, give date. Do you intend to renew? \_\_\_\_\_  Yes  No
- 4 Do you intend to qualify for a higher grade certificate?  Yes  No  
If "Yes," when? \_\_\_\_\_
- 5 Do you hold a current FAA medical certificate?  Yes  No  
Date last renewed. \_\_\_\_\_ If expired, do you intend to renew? . . . . .  Yes  No  
When? \_\_\_\_\_

6 Schedule of flying time Type of Flying	Hours as Pilot or Copilot			Hours as Passenger or Crew Member		
	Contemplated Next 12 Months	Past 12 Months	One to Two Years Ago	Contemplated Next 12 Months	Past 12 Months	One to Two Years Ago
COMMERCIAL (flying for pay) Scheduled passenger airline.....						
Employer-owned aircraft for employee transportation.....						
Crop dusting or aerial spraying.....						
Check flying of repaired or production line aircraft.....						
Student instruction.....						
Freight carrying or nonscheduled passenger service, charter or sight-seeing flying.....						
Other (describe below).....						
MILITARY.....						
NONCOMMERCIAL (not flying for pay) Pleasure.....						
Personal business transportation.....						
Instruction as student.....						
Other (describe below).....						

- 7 Total number of hours flown as a pilot.
- 8 Have you flown, or do you intend to fly a prototype, experimental, or home built aircraft? . . . . .  Yes  No
- 9 Do you or have you ever participated in aerobatics, air racing, or stunt flying? . . . . .  Yes  No
- 10 Do you contemplate any type of flying not indicated above? . . . . .  Yes  No  
If "Yes," please explain in **Part 12, "Additional Remarks."**
- 11 Have you ever had an aircraft accident or been grounded, fined or reprimanded for violation  
of air regulations? . . . . .  Yes  No
- 12 **ADDITIONAL REMARKS CLARIFYING ANSWERS TO ABOVE QUESTIONS. Give details of all questions answered "Yes."**  
(Use reverse side of form if necessary.)

\_\_\_\_\_

\_\_\_\_\_

I hereby represent that all the statements and answers to the above questions are true and complete to the best of my knowledge and belief, and will be relied upon to determine my eligibility for insurance. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage.

\_\_\_\_\_  
Witnessed Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date