

**State:** Arkansas **Filing Company:** The Union Labor Life Insurance Company  
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.203 Specified Age or Duration - Single Premium - Single Life  
**Product Name:** INDIVIDUAL TERM LIFE INSURANCE  
**Project Name/Number:** /

## Filing at a Glance

Company: The Union Labor Life Insurance Company  
Product Name: INDIVIDUAL TERM LIFE INSURANCE  
State: Arkansas  
TOI: L04I Individual Life - Term  
Sub-TOI: L04I.203 Specified Age or Duration - Single Premium - Single Life  
Filing Type: Form  
Date Submitted: 10/23/2012  
SERFF Tr Num: ULCC-128739435  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: ULLA-LIF-0112 (MIB REVISION)  
  
Implementation: On Approval  
Date Requested:  
Author(s): Carla Wallace  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 10/29/2012  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** The Union Labor Life Insurance Company  
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.203 Specified Age or Duration - Single Premium - Single Life  
**Product Name:** INDIVIDUAL TERM LIFE INSURANCE  
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## General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Overall Rate Impact:
Filing Status Changed: 10/29/2012	
State Status Changed: 10/29/2012	Deemer Date:
Created By: Carla Wallace	Submitted By: Carla Wallace
Corresponding Filing Tracking Number:	

**Filing Description:**  
 RE: INDIVIDUAL LIFE INSURANCE APPLICATION. ULLA-LIF-0112

The Union Labor Life Insurance Company  
 NAIC Number: 781-69744  
 FEIN: 13-1423090

Dear Sir or Madam:

Please find enclosed Individual Life Insurance Application form ULLA-LIF-0112 . This application form was approved for use by the Department on April 2, 2012. Please refer to SERFF Tracking Number: ULCC-128301660.

The purpose of this filing is to revised the Medical Investigation Bureau (MIB) language to conform to newly adopted MIB authorization language. No other changes have been made to this form as previosuly approved.

Please advise us of your decision at your earliest convenience.

## Company and Contact

### Filing Contact Information

Carla Wallace, Compliance Analyst	cwallace@ullico.com
8403 Colesville Rd	202-962-2901 [Phone]
Silver Spring, MD 20910	

### Filing Company Information

The Union Labor Life Insurance Company	CoCode: 69744	State of Domicile: Maryland
8403 Colesville Road	Group Code: 781	Company Type: Life and Health
Silver Spring, MD 20910	Group Name:	State ID Number:
(202) 682-0900 ext. [Phone]	FEIN Number: 13-1423090	

## Filing Fees

**State:** Arkansas **Filing Company:** The Union Labor Life Insurance Company  
**TOI/Sub-TOI:** L04I Individual Life - Term/L04I.203 Specified Age or Duration - Single Premium - Single Life  
**Product Name:** INDIVIDUAL TERM LIFE INSURANCE  
**Project Name/Number:** /

Fee Required? Yes  
Fee Amount: \$125.00  
Retaliatory? Yes  
Fee Explanation: 1 form at \$125.00 + \$125.00  
Per Company: No

Company	Amount	Date Processed	Transaction #
The Union Labor Life Insurance Company	\$125.00	10/23/2012	64163898

SERFF Tracking #:

ULCC-128739435

State Tracking #:

Company Tracking #:

ULLA-LIF-0112 (MIB REVISION)

State:

Arkansas

Filing Company:

The Union Labor Life Insurance Company

TOI/Sub-TOI:

L041 Individual Life - Term/L041.203 Specified Age or Duration - Single Premium - Single Life

Product Name:

INDIVIDUAL TERM LIFE INSURANCE

Project Name/Number:

/

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/29/2012	10/29/2012

SERFF Tracking #:

ULCC-128739435

State Tracking #:

Company Tracking #:

ULLA-LIF-0112 (MIB REVISION)

State:

Arkansas

Filing Company:

The Union Labor Life Insurance Company

TOI/Sub-TOI:

L041 Individual Life - Term/L041.203 Specified Age or Duration - Single Premium - Single Life

Product Name:

INDIVIDUAL TERM LIFE INSURANCE

Project Name/Number:

/

## Disposition

Disposition Date: 10/29/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	ULLA-LIF-0112 Redlined Highlighted Copy		Yes
Form	Individual Life Insurance Application		Yes

State: Arkansas

Filing Company:

The Union Labor Life Insurance Company

TOI/Sub-TOI: L041 Individual Life - Term/L041.203 Specified Age or Duration - Single Premium - Single Life

Product Name: INDIVIDUAL TERM LIFE INSURANCE

Project Name/Number: /

## Form Schedule

### Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Individual Life Insurance Application	ULLA-LIF-0112	AEF	Other	MIB Text Update	50.700	ULLA-LIF-0112.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

**INDIVIDUAL LIFE INSURANCE APPLICATION  
THE UNION LABOR LIFE INSURANCE COMPANY**

[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910]  
[Executive Office: 1625 Eye Street, N.W., Washington, D.C 20006 ]

[ John Q. Sample  
Street Road  
Second Address Line  
Anytown, US 00000 ]

[Member of: International Union Personalized]

**1. Please tell us about yourself:**

[Proposed Insured Name: [John Doe]  
Address 1 [123 ABC Lane]  
Address 2 [Unit 7654]  
City, State, Zip [Capris, IA 73259]  
Date of Birth  
[ ][ ] [ ][ ] [ ][ ][ ][ ]  
MONTH DAY YEAR  
 Male  Female  
State of Birth: [ ][ ]  
Phone [ ][ ][ ][ ] [ ][ ][ ][ ][ ][ ][ ][ ]  
AREA CODE  
Best time to call:  Morning  Afternoon  Evening  
Social Security # [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ]  
Driver's License# \_\_\_\_\_ State of Issue [ ][ ]  
E-Mail Address \_\_\_\_\_  
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

**If Owner is different from the Proposed Insured, please answer:**

Owner Name: [Jane Doe]  
Address 1 [123 ABC Lane]  
Address 2 [Unit 7654]  
City, State, Zip [Capris, IA 31529]  
Date of Birth  
[ ][ ] [ ][ ] [ ][ ][ ][ ]  
MONTH DAY YEAR  
 Male  Female  
Your relationship to Proposed Insured: \_\_\_\_\_  
Phone [ ][ ][ ][ ] [ ][ ][ ][ ][ ][ ][ ][ ]  
AREA CODE  
Best time to call:  Morning  Afternoon  Evening  
Social Security # [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ]  
Driver's License# \_\_\_\_\_ State of Issue [ ][ ]  
E-Mail Address \_\_\_\_\_  
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

[Please answer the following questions for the Proposed Insured:

International Union Name \_\_\_\_\_ Local # \_\_\_\_\_ Currently employed?  Yes  No  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
(street, city, state, zip)  
Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Personal Earned Income \$ \_\_\_\_\_ Household Income \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_ ]

**2. Please select the benefits that you would like:**

**Choose One Product Below:**

- 10 Year Term     15 Year Term  
 20 Year Term     25 Year Term     Other \_\_\_\_\_

**Choose One Coverage Amount Below:**

- \$250,000     \$200,000     \$150,000     \$100,000  
 \$75,000     \$50,000     \$25,000     Other \_\_\_\_\_

**Please check any additional coverage that you would like:**

- Accidental Death Benefit Rider: Coverage Amount:  \$100,000     \$75,000     \$50,000     \$25,000     Other \_\_\_\_\_  
 Children's Term Life Insurance Benefit Rider: Coverage Amount:  \$10,000     \$5,000     Other \_\_\_\_\_

List child(ren)'s name(s) and date(s) of birth in the section below:

Name \_\_\_\_\_ Date of birth

Name \_\_\_\_\_ Date of birth

Use a separate sheet of paper if more space is needed. Please be sure to sign and date it.

- Will this insurance policy replace or change any life insurance or annuity contract in force with The Union Labor Life or any other company?  Yes  No
- Is this policy being purchased with the intent of assigning or selling it to a third party?  Yes  No
- Do you have existing life insurance or annuity contracts with Union Labor Life or any other company?  Yes  No

**If you answered "Yes" to any of the above questions, please provide the details in the space below. Identify the question number, and include insurance company names, addresses and telephone numbers. Attach a separate sheet if needed. Please be sure to sign and date it.**

Please complete the beneficiary information:

Your Beneficiary \_\_\_\_\_  
 Relationship to the Proposed Insured \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_

Social Security Number

**3. Please answer the following questions for the Proposed Insured:**

Height \_\_\_\_\_ FEET/INCHES      Weight \_\_\_\_\_ LBS.

1. Have you plead guilty to or been convicted of driving under the influence of alcohol or drugs in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you had your driver's license suspended or revoked for any reason in the past 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had a heart attack or stroke within the past 6 months, been diagnosed or treated for cancer (other than skin cancer) within the past 2 years, or ever tested positive for HIV (Human Immunodeficiency Virus) infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 5 years, has a medical professional diagnosed you with, treated you for, or medically advised you to seek treatment because of: disease or disorder of the heart (including high blood pressure), blood or circulatory system, lungs, liver, bowel or kidneys, diabetes, stroke or cancer, mental or nervous disorders, or told you to reduce or discontinue use of any drug or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the last 5 years, have you been treated, diagnosed or advised by a member of a medical profession to seek treatment for any disease or disorder not mentioned above which requires ongoing or future medical care which has not been completed except for those test related to	<input type="checkbox"/> Yes <input type="checkbox"/> No

HIV/AIDS?	
6. Within the past six weeks, have you been prescribed or taken any prescription medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you used any tobacco or nicotine based products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered “Yes” to any of the above questions, please provide details in the space below. Identify the question number, and include diagnoses, dates, durations, names, addresses and phone numbers of all attending physicians and medical facilities. Attach a separate sheet if needed. Please be sure to sign and date it.**

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**4. Read, Sign and Date below.**

I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. I agree that this application will be the basis for, and will become part of, the policy that is issued. I understand that the statements and answers in the application are the basis for any policy issued by the company and that no information about me will be considered given unless stated in the application. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by The Union Labor Life Insurance Company (“the Company”) and all premiums have been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy’s Incontestability provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows Us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice, and Fair Credit Reporting Act Notice.

The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company.

I understand that state insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued, and that I should consult with legal advisors if I have any questions about these matters.

**Authorization**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran’s Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, a Department of Motor Vehicles, my employer, or any other person or organization that has any record of information about me to give The Union Labor Life Insurance Company, its reinsurers or its authorized representatives information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs, alcoholism, or other information The Union Labor Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above except for MIB, Inc. to give such information to a consumer reporting agency acting on behalf of The Union Labor Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to the Company at its administrative office address. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 30 months from the date signed.

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.

**[Information Practices Notice**

To determine eligibility for coverage, the Company may supplement the information provided by you with information from other sources. Any information you give us regarding your insurability, and any information received from other sources, will be treated as strictly confidential. In some situations, and in compliance with applicable laws, the Company may disclose necessary items of information to third parties without your specific authorization. You have the right to be told about, and to copy, if you wish, items of personal information which appear in Our files. You also have the right to seek correction of information you believe to be inaccurate. If you would like a more detailed explanation of our information practices and the circumstances under which we may use or disclose information, please submit a written request to the Company, to the attention of the Privacy Officer at the Executive Office address.]

**[Information Regarding the Medical Information Bureau Pre-Notice**

Information regarding your insurability will be treated as confidential. I authorize The Union Labor Life Insurance Company or its reinsurers to make a brief report of my protected health information to the 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 member. 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.

The Union Labor 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 <http://www.mib.com>.]

<p>X _____ <b>Proposed Insured Signature</b> <b>Date</b></p> <p>[Signed at _____ <b>City, State]</b></p>	<p>X _____ <b>Owner Signature</b> <b>Date</b> <i>(If different from Proposed Insured)</i></p> <p>[Signed at _____ <b>City, State]</b></p>
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**Agent Certification**

I certify that: (1) the application was obtained personally and in my presence; (2) all questions on the application were asked, and any information recorded by me on this application is true and accurate to the best of my knowledge; (3) to the best of my knowledge, this policy will  will not  replace or change any existing life insurance or annuity policy(ies); and (4) I have witnessed the signature(s) on this application.

\_\_\_\_\_  
Licensed Agent's Signature

\_\_\_\_\_  
Agent's Printed Name

\_\_\_\_\_  
Agent's Number

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
License #

\_\_\_\_\_  
State

\_\_\_\_\_  
Date

**Mail Policy To:**  Owner  Agent

SERFF Tracking #:

ULCC-128739435

State Tracking #:

Company Tracking #:

ULLA-LIF-0112 (MIB REVISION)

State:

Arkansas

Filing Company:

The Union Labor Life Insurance Company

TOI/Sub-TOI:

L041 Individual Life - Term/L041.203 Specified Age or Duration - Single Premium - Single Life

Product Name:

INDIVIDUAL TERM LIFE INSURANCE

Project Name/Number:

/

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Document Attached.		
Attachment(s):			
CERTIFICATE OF READABILITY.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Fprm has been provided in form schedule for review of the MIB language.		

		Item Status:	Status Date:
Satisfied - Item:	ULLA-LIF-0112 Redlined Highlighted Copy		
Comments:	Document Attached.		
Attachment(s):			
ULLA-LIF-0112 Redlined Highlighted Copy.pdf			

# The Union Labor Life Insurance Company

("We, Us, Our, the Company")

Administrative Office: 8403 Colesville Road, Silver Spring, Maryland 20910

Executive Office: 1625 Eye Street N.W., Washington DC 20006

## READABILITY CERTIFICATION

I certify that the form submitted with this filing achieved the following score using the Flesch Test Reading Score standards.

<b>Form</b>	<b>Description</b>	<b>Score</b>
ULLA-LIF-0112	Individual Life Insurance Application	50.7



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**Stephanie Whalen**  
**Vice President, Operations**

October 23, 2012

**INDIVIDUAL LIFE INSURANCE APPLICATION**  
**THE UNION LABOR LIFE INSURANCE COMPANY**

[ Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910 ]  
[ Executive Office: 1625 Eye Street, N.W., Washington, D.C 20006 ]

[ John Q. Sample  
Street Road  
Second Address Line  
Anytown, US 00000 ]

[ Member of: International Union Personalized ]

**1. Please tell us about yourself:**

[ Proposed Insured Name: [ John Doe ]  
Address 1 [ 123 ABC Lane ]  
Address 2 [ Unit 7654 ]  
City, State, Zip [ Capris, IA 73259 ]  
Date of Birth  
[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
MONTH DAY YEAR  
 Male  Female  
State of Birth: [ ] [ ]  
Phone [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
AREA CODE  
Best time to call:  Morning  Afternoon  Evening  
Social Security # [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
Driver's License# \_\_\_\_\_ State of Issue [ ] [ ]  
E-Mail Address \_\_\_\_\_  
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

**If Owner is different from the Proposed Insured, please answer:**

Owner Name: [ Jane Doe ]  
Address 1 [ 123 ABC Lane ]  
Address 2 [ Unit 7654 ]  
City, State, Zip [ Capris, IA 31529 ]  
Date of Birth  
[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
MONTH DAY YEAR  
 Male  Female  
Your relationship to Proposed Insured: \_\_\_\_\_  
Phone [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
AREA CODE  
Best time to call:  Morning  Afternoon  Evening  
Social Security # [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
Driver's License# \_\_\_\_\_ State of Issue [ ] [ ]  
E-Mail Address \_\_\_\_\_  
If you share your e-mail address, you may receive periodic e-mails about money-saving benefits endorsed by your Union. You will always have the right to opt-out of receiving these e-mails.

[ Please answer the following questions for the Proposed Insured:

International Union Name \_\_\_\_\_ Local # \_\_\_\_\_ Currently employed?  Yes  No  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
(street, city, state, zip)  
Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_  
Personal Earned Income \$ \_\_\_\_\_ Household Income \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_ ]



HIV/AIDS?	
6. Within the past six weeks, have you been prescribed or taken any prescription medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you used any tobacco or nicotine based products in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered “Yes” to any of the above questions, please provide details in the space below. Identify the question number, and include diagnoses, dates, durations, names, addresses and phone numbers of all attending physicians and medical facilities. Attach a separate sheet if needed. Please be sure to sign and date it.**

---

**4. Read, Sign and Date below.**

I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. I agree that this application will be the basis for, and will become part of, the policy that is issued. I understand that the statements and answers in the application are the basis for any policy issued by the company and that no information about me will be considered given unless stated in the application. The above representations are true to the best of my knowledge and belief. I agree the policy shall not be in effect until it has been issued by The Union Labor Life Insurance Company (“the Company”) and all premiums have been paid. I understand that the information on this application will be relied upon to determine insurability and that incorrect information may result in coverage being voided, subject to the policy’s Incontestability provision. I understand that the agent has no authority to approve the application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows Us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided. I am not being paid cash and have not been promised services as an inducement to enter into this application for life insurance. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice, and Fair Credit Reporting Act Notice.

The purpose of this insurance application is not to sell or assign it to any type of viatical settlement, senior settlement, or life settlement company.

I understand that state insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued, and that I should consult with legal advisors if I have any questions about these matters.

**Authorization**

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran’s Administration, insurance company, MIB, Inc., pharmacy manager, pharmacy, insurance laboratory, a consumer reporting agency, a Department of Motor Vehicles, my employer, or any other person or organization that has any record of information about me to give The Union Labor Life Insurance Company, its reinsurers or its authorized representatives information about my health, other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs, alcoholism, or other information The Union Labor Life Insurance Company requires to determine insurability or eligibility of benefits. I further authorize the sources listed above except for MIB, Inc. to give such information to a consumer reporting agency acting on behalf of The Union Labor Life Insurance Company. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to the Company at its administrative office address. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 30 months from the date signed.

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.

**Information Practices Notice**

To determine eligibility for coverage, the Company may supplement the information provided by you with information from other sources. Any information you give us regarding your insurability, and any information received from other sources, will be treated as strictly confidential. In some situations, and in compliance with applicable laws, the Company may disclose necessary items of information to third parties without your specific authorization. You have the right to be told about, and to copy, if you wish, items of personal information which appear in Our files. You also have the right to seek correction of information you believe to be inaccurate. If you would like a more detailed explanation of our information practices and the circumstances under which we may use or disclose information, please submit a written request to the Company, to the attention of the Privacy Officer at the Executive Office address.]

**Information Regarding the Medical Information Bureau Pre-Notice**

Information regarding your insurability will be treated as confidential. ~~The Union Labor Life Insurance Company or its reinsurers may; however, make a brief report thereon to the 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.~~ I authorize The Union Labor Life Insurance Company or its reinsurers to make a brief report of my protected health information to the 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 member. 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.

The Union Labor 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 <http://www.mib.com>.]

X \_\_\_\_\_  
Proposed Insured Signature Date

[Signed at \_\_\_\_\_  
City, State]

X \_\_\_\_\_  
Owner Signature Date  
(If different from Proposed Insured)

[Signed at \_\_\_\_\_  
City, State]

**[Agent Certification**

I certify that: (1) the application was obtained personally and in my presence; (2) all questions on the application were asked, and any information recorded by me on this application is true and accurate to the best of my knowledge; (3) to the best of my knowledge, this policy will  will not  replace or change any existing life insurance or annuity policy(ies); and (4) I have witnessed the signature(s) on this application.

\_\_\_\_\_  
Licensed Agent's Signature

\_\_\_\_\_  
Agent's Printed Name

\_\_\_\_\_  
Agent's Number

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-mail Address

\_\_\_\_\_  
License #

\_\_\_\_\_  
State

\_\_\_\_\_  
Date

**Mail Policy To:**  Owner  Agent