

State: Arkansas **Filing Company:** United Life Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: LIU-113 (1-11)
Project Name/Number: /

Filing at a Glance

Company: United Life Insurance Company
Product Name: LIU-113 (1-11)
State: Arkansas
TOI: L04I Individual Life - Term
Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Filing Type: Form
Date Submitted: 10/12/2012
SERFF Tr Num: UNFG-128726602
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: LIU-113 (1-13)

Implementation: 01/01/2013
Date Requested:
Author(s): Joanne Young
Reviewer(s): Linda Bird (primary)
Disposition Date: 10/16/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** United Life Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: LIU-113 (1-11)
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General Information

| | |
|--|---------------------------------------|
| Project Name: | Status of Filing in Domicile: Pending |
| Project Number: | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Individual Market Type: |
| Overall Rate Impact: | Filing Status Changed: 10/16/2012 |
| | State Status Changed: 10/16/2012 |
| Deemer Date: | Created By: Joanne Young |
| Submitted By: Joanne Young | Corresponding Filing Tracking Number: |

Filing Description:
 MIB REQUIRED CHANGE TO MIB AUTHORIZAITON EFFECTIVE 1/1/2013

LIU-113 (1-13) Application for Life Insurance

We are filing a revised application to be used with our life products. This will replace form LIU-113 (1-11) which was approved by your office on 10/26/2010. That was SERFF number UNFG-126861507.

The only revision from the LIU-113 (1-11) version form is the MIB required change effective 1/1/2013. I have attached, in the supporting documentation tab, the (1-11) version with a redline showing what text was removed and the LIU-113 (1-13) version with highlighted text showing what was added. The change is on page 4 of the form. No other changes have been made to the fom except to revise the form number.

Thank you for your consideration.

Company and Contact

Filing Contact Information

| | |
|-----------------------------|----------------------------|
| Joanne Young, Analyst | jyoung@unitedfiregroup.com |
| 118 2nd Ave SE | 319-286-2620 [Phone] |
| PO Box 73909 | 319-286-2570 [FAX] |
| Cedar Rapids, IA 52407-3909 | |

Filing Company Information

| | | |
|-------------------------------|-------------------------------|-------------------------|
| United Life Insurance Company | CoCode: 69973 | State of Domicile: Iowa |
| 118 2nd Ave SE | Group Code: 248 | Company Type: Life |
| PO Box 73909 | Group Name: United Fire Group | State ID Number: |
| Cedar Rapids, IA 52407-3909 | FEIN Number: 42-6061188 | |
| (319) 399-5700 ext. [Phone] | | |

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:

State: Arkansas Filing Company: United Life Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: LIU-113 (1-11)
Project Name/Number: /

Per Company: No

| Company | Amount | Date Processed | Transaction # |
|-------------------------------|---------|----------------|---------------|
| United Life Insurance Company | \$50.00 | 10/12/2012 | 63783381 |

State: Arkansas Filing Company: United Life Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: LIU-113 (1-11)
Project Name/Number: /

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 10/16/2012 | 10/16/2012 |

SERFF Tracking #:

UNFG-128726602

State Tracking #:

Company Tracking #:

LIU-113 (1-13)

State:

Arkansas

Filing Company:

United Life Insurance Company

TOI/Sub-TOI:

L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name:

LIU-113 (1-11)

Project Name/Number:

/

Disposition

Disposition Date: 10/16/2012

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 | | No |
| Supporting Document | Life & Annuity - Acturial Memo | | No |
| Supporting Document | redline and highlighted changes | | Yes |
| Form | Application for Life Insurance | | Yes |

SERFF Tracking #:

UNFG-128726602

State Tracking #:

Company Tracking #:

LIU-113 (1-13)

State: Arkansas

Filing Company:

United Life Insurance Company

TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: LIU-113 (1-11)

Project Name/Number: /

Form Schedule

Lead Form Number: LIU-113 (1-13)

| Item No. | Schedule Item Status | Form Number | Form Type | Form Name | Action/Action Specific Data | Readability Score | Attachments |
|----------|----------------------|----------------|-----------|--------------------------------|-----------------------------|-------------------|--------------------|
| 1 | | LIU-113 (1-11) | AEF | Application for Life Insurance | Initial: | 0.000 | LIU-113 (1-11).pdf |

Form Type Legend:

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



APPLICATION FOR LIFE INSURANCE

| PROPOSED INSURED A | PROPOSED INSURED B (Other insured) |
|--|--|
| Name _____ | Name _____ |
| Street Address _____ | Address _____ |
| City _____ State _____ Zip _____ | City _____ State _____ Zip _____ |
| Soc.Sec. # _____ U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No | SS# _____ U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of Birth _____ Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female | D.O.B. _____ Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Phone _____ | Home Phone _____ |
| Driver's License # _____ | Driver's License # _____ |
| Occupation _____ Employer _____ | Occupation _____ Employer _____ |
| Work Phone _____ | Work Phone _____ |
| Other Life Insurance in force? <input type="checkbox"/> Yes <input type="checkbox"/> No Total Amt. \$ _____ | <input type="checkbox"/> yes <input type="checkbox"/> no \$ _____ |
| Have you smoked cigarettes in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Used any tobacco/nicotine products in the past 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> yes <input type="checkbox"/> no |

RATE CLASS

Standard (Cigarette smoker)
 Select (No cigarettes for 12 months, other tobacco acceptable)
 Preferred (Minimum \$100,000 face amount. **NOT available for SPWL.** No tobacco or nicotine products for 24 months.)

Owner (if different than insured) _____ Date of Birth _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

Relationship to the insured _____ Individual Corp LLC Partnership Other

Tax ID/SS # _____ U.S. Citizen Yes No

Contingent Owner (Required if proposed insured is a minor) _____

Payor Name (if different than owner) _____ Tax ID/SS Number _____

Billing Address _____ City _____ State _____ Zip _____ U.S. Citizen Yes No

FACE AMOUNT \$ _____
 (\$1,000,000+, complete Large Amt. Supplement)

PLAN

(1) **Uni-3*** Level Increasing
 Cost of Living

(2) **Whole Life**

(3) **5-Pay Whole Life** **10-Pay Whole Life**
 20-Pay Whole Life

(4) **Single Premium Whole Life**
 Guaranteed Ins. Option \$ _____
 Number of Options (1-5) _____
 Final Total Benefit \$ _____

(5) **Term Renewable & Convertible Term**
 Annual* 5-Yr.* 10-Yr.* 20-Yr.

*** Submit NAIC compliant illustration**

| RIDERS (by plan number) | Proposed Insured A | Proposed Insured B |
|---|------------------------------|--|
| <input type="checkbox"/> Other Insured Rider (1, 5) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Other Insured 20-Year Term (1, 2) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Accidental Death (1, 2, 5) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Disability Waiver (1, 2, 3, 5) <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Disability Income 2-Year Limited Benefit (1, 2, 5) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Disability Income to 65 <input type="checkbox"/> 30 day <input type="checkbox"/> 180 day (1, 2, 5) | \$ _____ | <input type="checkbox"/> 30 day <input type="checkbox"/> 180 day |

For DI coverage complete earnings on page 3.

RIDERS Available to Insured A only

| | |
|--|----------|
| <input type="checkbox"/> Additional Term Insurance (1) | \$ _____ |
| <input type="checkbox"/> Qualified Care Accelerated Death Benefit (1) | \$ _____ |
| <input type="checkbox"/> 20-Year Additional Term Ins. (1, 2) | \$ _____ |
| <input type="checkbox"/> UNI-3 Scheduled Increase Option (1) | \$ _____ |
| <input type="checkbox"/> Whole Life Guaranteed Insurability Option (2) | \$ _____ |
| <input type="checkbox"/> Children's Term Rider (1, 2, 5) See page 3. | \$ _____ |

Premium/Payment Mode

Planned 1st Yr. or **Annual Premium** \$ _____ **Bank Withdrawal (EFT)** Draft Date _____

Additional lump sum \$ _____ Mo Qrtly (**Attach voided check**)

Cash with app \$ _____ Please draft initial premium upon receipt of this application

1035(a) Exchange? Yes No COD **Mail Bill to payor:** Mo Qrtly SA Ann. or Single Prem. Paymt

List Bill Mo Qrtly SA Ann. If existing List Bill # AA _____

"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 or may be guilty of a crime and may be subject to fines and confinement in prison."

When we use the words **you** or **your** in this application, we mean **Proposed Insured A** or **Proposed Insured B**.

MEDICAL

Proposed Insured A **Proposed Insured B**

1. (A) Ht. _____ ft. _____ in. Wt. _____ (B) Ht _____ ft. _____ in. Wt. _____

2. Provide the name, address and phone number of your personal physician along with the date and reason last seen.

Dr. Name _____ Phone _____

Address _____

Date and reason last seen: _____

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 3. Have you ever applied for or been examined for life, accident or health insurance that was declined or modified as to rate or amount? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had or been told by a medical practitioner that you have the following: | | | | |
| A. Respiratory or lung disease, brain, nervous or mental disease, depression or anxiety, seizures or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Liver disease, colitis, diabetes, sugar in urine, cancer, tumor, disease of the prostate, kidney or urinary tract? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. High blood pressure, chest pain, heart disease, arrhythmia, stroke or other cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Back, bone or joint pain, arthritis, Alzheimer s or Parkinson s disease, muscular disease or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Alcohol or drug problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Chronic diarrhea, abdominal disease, blood, gland, spleen or skin disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been diagnosed or treated by a medical professional for an immune deficiency disorder, HIV, AIDS or ARC? (In Wisconsin, the reporting of HIV tests is limited to the positive results of FDA licensed tests, and AIDS tests results obtained at anonymous counseling and testing sites are confidential and need not be disclosed)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past five years have you used or do you now use barbituates, amphetamines, narcotics, hallucinogens, marijuana, cocaine or any prescription drug except by physician s prescription?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you taken any prescription medication during the last 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Any other accident, injury, operation or medical attention within the past five years not stated above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been unable to work during the past three years due to illness or accident? (Disregard minor non-recurring illnesses.)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. During the past three years have you been charged with three or more moving vehicle violations or during the past five years been convicted of a DWI or DUI? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you taken any aerial flight other than as a fare-paying passenger on a commercial airline?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you participate in any hazardous avocation, occupation or sport? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you been convicted of or pled guilty or no contest to a felony in the past ten years?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a parent or sibling die prior to age 60 due to heart disease, diabetes or cancer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you intend to travel outside the United States for reasons other than recreational purposes?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have existing insurance or annuity contracts with this or any other company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Is this insurance intended to replace existing insurance or annuity with this or any other company? .. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to either question 16 or 17, complete the replacement form as required by state law and submit it with this application.

Explain any YES answers to questions 1-15. Provide details, dates, diagnosis, reason for prescriptions, etc.

BENEFICIARY DESIGNATION (will be Revocable and Per Stirpes if not indicated.)

PER STIRPES—if a named beneficiary dies before the insured, proceeds will be paid to the surviving direct descendants of that beneficiary.

PER CAPITA—if named beneficiary dies before the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

| PROPOSED INSURED A | PROPOSED INSURED B (OTHER INSURED RIDER) |
|---|---|
| Primary <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ | Primary <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ |
| Contingent <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ | Contingent <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ |

ASSIGNMENT Is this policy assigned? Yes No

If yes, must attach a completed assignment form in order for assignment to be effective for this policy.

APPLICATION FOR CHILDREN S COVERAGE Children of the proposed insured who have not reached their 19th birthday

| Name | DOB | Injury, illness or history of medical problems within the past 5 yrs.? |
|-------|-------|--|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have any of these children applied or been examined for life, accident or health insurance that was declined or modified as to rate or amount? Yes No If yes, give details.

Provide doctor s name and address. _____

DISABILITY INCOME BENEFITS (Complete only if applying for over \$500 in DI benefits)

Other disability insurance in force? (A) Yes No
 (B) Yes No

If yes, please provide details and identify by A or B.

| Monthly Benefit | Benefit Period | Company |
|-----------------|----------------|---------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Statement of Earnings

Earnings last year (A) \$ _____
 (B) \$ _____
 Earnings for prior year (A) \$ _____
 (B) \$ _____

IRS Taxpayer Certification

Under penalties of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

Medical Authorization

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, employer, or the Medical Information Bureau, Inc., to give United Life Insurance Company all information from the past 10 years that it holds, that pertains to medical consultations, treatments, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. United Life Insurance Company or its reinsurers may release information to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This Authorization shall be in force for 24 months following the date of my signature, except in Arizona, where the authorization to disclose HIV related information shall be in force for 180 days. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at 118 Second Avenue SE, Cedar Rapids, Iowa 52407. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United Life 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 of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United Life 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 and I agree that a photocopy of this Authorization shall be as valid as the original.

Acknowledgement

I (we) have read this application in its entirety. I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.

City and State where signed _____ **Date** _____

X _____

SIGNATURE OF PROPOSED INSURED A
(or parent if Proposed Insured is a minor)

X _____

SIGNATURE OF PROPOSED INSURED B
(or parent if Proposed Insured is a minor)

X _____

SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED A

X _____

I, the **AGENT**, certify that I have used only insurer-approved or provided sales material. I also certify that I have left a copy of all sales material, replacement forms and disclosures with the applicant.

Are there existing life insurance or annuity contracts on the life of the insured(s)? Yes No

Is this policy intended to replace existing insurance or annuity with this or any other company? Yes No

SIGNATURE OF AGENT

AGENT S PRINTED NAME

AGENCY NAME AGENCY NUMBER %

AGENCY NAME AGENCY NUMBER %

Date _____



United Life Insurance Company
P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

CONDITIONAL RECEIPT

AGENT: VALID ONLY WHEN ONE MONTH PREMIUM HAS BEEN COLLECTED

Unless every condition specified in Paragraph "First" below is fulfilled exactly, no insurance will become effective prior to Policy Delivery. No agent of the Company may alter or waive any conditions.

Received from _____ this _____ day of _____, 20____
the sum of \$_____ in connection with this application for life insurance to United Life Insurance Company. The application bears the same date as this receipt. (Checks must be payable to United Life Insurance Company.)

All premium checks must be made payable to the insurance company. Do not make the check payable to the agent or leave the payee blank.

Type of Policy applied for: _____ (Generic Name)

FIRST. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery.

- (a) the amount of premium taken with the application must be at least equal to the amount of one full monthly premium for the amount of insurance which may become effective prior to policy delivery; and
- (b) all medical examinations, tests, electrocardiograms required by the Company must be completed within 60 days from the date of the application; and
- (c) the Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards for the plan and for the amount applied for without modification and at the rate of premium paid; and
- (d) with respect to any life insurance applied for the Proposed Insureds must be in good health on the Effective Date.

Then the insurance as applied for in an amount not exceeding \$100,000 will become effective as of the latest of: (a) the date of the application, or (b) the date of completion of all medical examinations, tests, and electrocardiograms required by the Company or (c) the Date of Issue, if any, requested on the application.

SECOND. Limits Provision:

The maximum amount of insurance which may become effective prior to policy delivery shall not exceed a total of \$100,000 for this and any other applications pending with this Company.

THIRD. Return of Premiums Paid.

If one or more of the conditions in paragraph "FIRST" have not been fulfilled exactly, there shall be no liability on the part of the Company except to return Premiums paid.

(Signature of Agent)



United Life Insurance Company

P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

NOTICES TO APPLICANTS

AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United 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. 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, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from the proposed insured(s), MIB will arrange disclosure of any information it may have on file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

United Life Insurance Company or its reinsurers may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at www.mib.com.

SERFF Tracking #:

UNFG-128726602

State Tracking #:

Company Tracking #:

LIU-113 (1-13)

State: Arkansas

Filing Company:

United Life Insurance Company

TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: LIU-113 (1-11)

Project Name/Number: /

Supporting Document Schedules

| | | Item Status: | Status Date: |
|-------------------|----------------------|--------------|--------------|
| Satisfied - Item: | Flesch Certification | | |
| Comments: | | | |
| Attachment(s): | | | |
| AR Cert.pdf | | | |

| | | Item Status: | Status Date: |
|------------------------|---------------------------------|--------------|--------------|
| Satisfied - Item: | redline and highlighted changes | | |
| Comments: | | | |
| Attachment(s): | | | |
| LIU-113 (1-11).pdf | | | |
| LIU-113 (1-13) add.pdf | | | |

CERTIFICATE OF COMPLIANCE

UNITED LIFE INSURANCE COMPANY

Form number: LIU-113 (1-13) Application for Life Insurance

I hereby certify to the best of my knowledge and belief that this filing is in compliance with Arkansas Regulations 19 and 49 and Bulletin 11-88.

Certified by:



Jean Newlin Schnake, Secretary
United Life Insurance Company

10-12-2012

Date



APPLICATION FOR LIFE INSURANCE

| PROPOSED INSURED A | PROPOSED INSURED B (Other insured) |
|--|--|
| Name _____ | Name _____ |
| Street Address _____ | Address _____ |
| City _____ State _____ Zip _____ | City _____ State _____ Zip _____ |
| Soc.Sec. # _____ U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No | SS# _____ U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of Birth _____ Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female | D.O.B. _____ Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Phone _____ | Home Phone _____ |
| Driver's License # _____ | Driver's License # _____ |
| Occupation _____ Employer _____ | Occupation _____ Employer _____ |
| Work Phone _____ | Work Phone _____ |
| Other Life Insurance in force? <input type="checkbox"/> Yes <input type="checkbox"/> No Total Amt. \$ _____ | <input type="checkbox"/> yes <input type="checkbox"/> no \$ _____ |
| Have you smoked cigarettes in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Used any tobacco/nicotine products in the past 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> yes <input type="checkbox"/> no |

| RATE CLASS | RATE CLASS |
|---|--|
| <input type="checkbox"/> Standard (Cigarette smoker) | <input type="checkbox"/> Standard <input type="checkbox"/> Select <input type="checkbox"/> Preferred |
| <input type="checkbox"/> Select (No cigarettes for 12 months, other tobacco acceptable) | |
| <input type="checkbox"/> Preferred (Minimum \$100,000 face amount. NOT available for SPWL. No tobacco or nicotine products for 24 months.) | |

Owner (if different than insured) _____ Date of Birth _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

Relationship to the insured _____ Individual Corp LLC Partnership Other

Tax ID/SS # _____ U.S. Citizen Yes No

Contingent Owner (Required if proposed insured is a minor) _____

Payor Name (if different than owner) _____ Tax ID/SS Number _____

Billing Address _____ City _____ State _____ Zip _____ U.S. Citizen Yes No

| FACE AMOUNT \$ _____ (\$1,000,000+, complete Large Amt. Supplement) | RIDERS (by plan number) Proposed Insured A | Proposed Insured B | |
|---|--|--|--|
| PLAN (1) <input type="checkbox"/> Uni-3* <input type="checkbox"/> Level <input type="checkbox"/> Increasing <input type="checkbox"/> Cost of Living (2) <input type="checkbox"/> Whole Life (3) <input type="checkbox"/> 5-Pay Whole Life <input type="checkbox"/> 10-Pay Whole Life <input type="checkbox"/> 20-Pay Whole Life (4) <input type="checkbox"/> Single Premium Whole Life <input type="checkbox"/> Guaranteed Ins. Option \$ _____ Number of Options (1-5) _____ Final Total Benefit \$ _____ (5) <input type="checkbox"/> Term Renewable & Convertible Term <input type="checkbox"/> Annual* <input type="checkbox"/> 5-Yr.* <input type="checkbox"/> 10-Yr.* <input type="checkbox"/> 20-Yr. * Submit NAIC compliant illustration | <input type="checkbox"/> Other Insured Rider (1, 5) \$ _____ <input type="checkbox"/> Other Insured 20-Year Term (1, 2) \$ _____ <input type="checkbox"/> Accidental Death (1, 2, 5) \$ _____ <input type="checkbox"/> Disability Waiver (1, 2, 3, 5) <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ <input type="checkbox"/> Disability Income 2-Year Limited Benefit (1, 2, 5) \$ _____ <input type="checkbox"/> Disability Income to 65 <input type="checkbox"/> 30 day <input type="checkbox"/> 180 day (1, 2, 5) \$ _____ For DI coverage complete earnings on page 3. | \$ _____ \$ _____ \$ _____ <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____ <input type="checkbox"/> 30 day <input type="checkbox"/> 180 day \$ _____ | |
| | RIDERS Available to Insured A only | | |
| | <input type="checkbox"/> Additional Term Insurance (1) \$ _____ <input type="checkbox"/> Qualified Care Accelerated Death Benefit (1) \$ _____ <input type="checkbox"/> 20-Year Additional Term Ins. (1, 2) \$ _____ <input type="checkbox"/> UNI-3 Scheduled Increase Option (1) \$ _____ <input type="checkbox"/> Whole Life Guaranteed Insurability Option (2) \$ _____ <input type="checkbox"/> Children's Term Rider (1, 2, 5) See page 3. \$ _____ | | |

Premium/Payment Mode

Planned 1st Yr. or **Annual Premium** \$ _____ **Bank Withdrawal (EFT)** Draft Date _____

Additional lump sum \$ _____ Mo Qrtly (**Attach voided check**)

Cash with app \$ _____ Please draft initial premium upon receipt of this application

1035(a) Exchange? Yes No COD **Mail Bill to payor:** Mo Qrtly SA Ann. or Single Prem. Paymt

List Bill Mo Qrtly SA Ann. If existing List Bill # AA _____

“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 or may be guilty of a crime and may be subject to fines and confinement in prison.”

When we use the words **you** or **your** in this application, we mean **Proposed Insured A** or **Proposed Insured B**.

MEDICAL

Proposed Insured A **Proposed Insured B**

1. (A) Ht. _____ ft. _____ in. Wt. _____ (B) Ht _____ ft. _____ in. Wt. _____

2. Provide the name, address and phone number of your personal physician along with the date and reason last seen.

Dr. Name _____ Phone _____

Address _____

Date and reason last seen: _____

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 3. Have you ever applied for or been examined for life, accident or health insurance that was declined or modified as to rate or amount? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had or been told by a medical practitioner that you have the following: | | | | |
| A. Respiratory or lung disease, brain, nervous or mental disease, depression or anxiety, seizures or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Liver disease, colitis, diabetes, sugar in urine, cancer, tumor, disease of the prostate, kidney or urinary tract? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. High blood pressure, chest pain, heart disease, arrhythmia, stroke or other cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Back, bone or joint pain, arthritis, Alzheimer s or Parkinson s disease, muscular disease or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Alcohol or drug problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Chronic diarrhea, abdominal disease, blood, gland, spleen or skin disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been diagnosed or treated by a medical professional for an immune deficiency disorder, HIV, AIDS or ARC? (In Wisconsin, the reporting of HIV tests is limited to the positive results of FDA licensed tests, and AIDS tests results obtained at anonymous counseling and testing sites are confidential and need not be disclosed)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past five years have you used or do you now use barbituates, amphetamines, narcotics, hallucinogens, marijuana, cocaine or any prescription drug except by physician s prescription?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you taken any prescription medication during the last 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Any other accident, injury, operation or medical attention within the past five years not stated above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been unable to work during the past three years due to illness or accident? (Disregard minor non-recurring illnesses.)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. During the past three years have you been charged with three or more moving vehicle violations or during the past five years been convicted of a DWI or DUI? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you taken any aerial flight other than as a fare-paying passenger on a commercial airline?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you participate in any hazardous avocation, occupation or sport? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you been convicted of or pled guilty or no contest to a felony in the past ten years?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a parent or sibling die prior to age 60 due to heart disease, diabetes or cancer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you intend to travel outside the United States for reasons other than recreational purposes?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have existing insurance or annuity contracts with this or any other company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Is this insurance intended to replace existing insurance or annuity with this or any other company? .. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If yes to either question 16 or 17, complete the replacement form as required by state law and submit it with this application.

Explain any YES answers to questions 1-15. Provide details, dates, diagnosis, reason for prescriptions, etc.

BENEFICIARY DESIGNATION (will be Revocable and Per Stirpes if not indicated.)

PER STIRPES—if a named beneficiary dies before the insured, proceeds will be paid to the surviving direct descendants of that beneficiary.

PER CAPITA—if named beneficiary dies before the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

| PROPOSED INSURED A | PROPOSED INSURED B (OTHER INSURED RIDER) |
|---|---|
| Primary <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ | Primary <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ |
| Contingent <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ | Contingent <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ |

ASSIGNMENT Is this policy assigned? Yes No

If yes, must attach a completed assignment form in order for assignment to be effective for this policy.

APPLICATION FOR CHILDREN S COVERAGE Children of the proposed insured who have not reached their 19th birthday

| Name | DOB | Injury, illness or history of medical problems within the past 5 yrs.? |
|-------|-------|--|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have any of these children applied or been examined for life, accident or health insurance that was declined or modified as to rate or amount? Yes No If yes, give details.

Provide doctor s name and address. _____

DISABILITY INCOME BENEFITS (Complete only if applying for over \$500 in DI benefits)

Other disability insurance in force? (A) Yes No
(B) Yes No

If yes, please provide details and identify by A or B.

| Monthly Benefit | Benefit Period | Company | Statement of Earnings |
|-----------------|----------------|---------|--------------------------------------|
| _____ | _____ | _____ | Earnings last year (A) \$ _____ |
| _____ | _____ | _____ | (B) \$ _____ |
| _____ | _____ | _____ | Earnings for prior year (A) \$ _____ |
| _____ | _____ | _____ | (B) \$ _____ |

IRS Taxpayer Certification

Under penalties of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

Medical Authorization

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, employer, or the Medical Information Bureau, Inc., to give United Life Insurance Company all information from the past 10 years that it holds, that pertains to medical consultations, treatments, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. ~~United Life Insurance Company or its reinsurers may release information to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.~~ United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This Authorization shall be in force for 24 months following the date of my signature, except in Arizona, where the authorization to disclose HIV related information shall be in force for 180 days. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at 118 Second Avenue SE, Cedar Rapids, Iowa 52407. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United Life 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 of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United Life 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 and I agree that a photocopy of this Authorization shall be as valid as the original.

Acknowledgement

I (we) have read this application in its entirety. I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.

City and State where signed _____ **Date** _____

X _____
SIGNATURE OF PROPOSED INSURED A
(or parent if Proposed Insured is a minor)

X _____
SIGNATURE OF PROPOSED INSURED B
(or parent if Proposed Insured is a minor)

X _____
SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED A

X _____

I, the **AGENT**, certify that I have used only insurer-approved or provided sales material. I also certify that I have left a copy of all sales material, replacement forms and disclosures with the applicant.

Are there existing life insurance or annuity contracts on the life of the insured(s)? Yes No

Is this policy intended to replace existing insurance or annuity with this or any other company? Yes No

SIGNATURE OF AGENT

AGENT S PRINTED NAME

AGENCY NAME AGENCY NUMBER %

AGENCY NAME AGENCY NUMBER %

Date _____



United Life Insurance Company
P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

CONDITIONAL RECEIPT

AGENT: VALID ONLY WHEN ONE MONTH PREMIUM HAS BEEN COLLECTED

Unless every condition specified in Paragraph "First" below is fulfilled exactly, no insurance will become effective prior to Policy Delivery. No agent of the Company may alter or waive any conditions.

Received from _____ this _____ day of _____, 20____
the sum of \$_____ in connection with this application for life insurance to United Life Insurance Company. The application bears the same date as this receipt. (Checks must be payable to United Life Insurance Company.)

All premium checks must be made payable to the insurance company. Do not make the check payable to the agent or leave the payee blank.

Type of Policy applied for: _____ (Generic Name)

FIRST. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery.

- (a) the amount of premium taken with the application must be at least equal to the amount of one full monthly premium for the amount of insurance which may become effective prior to policy delivery; and
- (b) all medical examinations, tests, electrocardiograms required by the Company must be completed within 60 days from the date of the application; and
- (c) the Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards for the plan and for the amount applied for without modification and at the rate of premium paid; and
- (d) with respect to any life insurance applied for the Proposed Insureds must be in good health on the Effective Date.

Then the insurance as applied for in an amount not exceeding \$100,000 will become effective as of the latest of: (a) the date of the application, or (b) the date of completion of all medical examinations, tests, and electrocardiograms required by the Company or (c) the Date of Issue, if any, requested on the application.

SECOND. Limits Provision:

The maximum amount of insurance which may become effective prior to policy delivery shall not exceed a total of \$100,000 for this and any other applications pending with this Company.

THIRD. Return of Premiums Paid.

If one or more of the conditions in paragraph "FIRST" have not been fulfilled exactly, there shall be no liability on the part of the Company except to return Premiums paid.

(Signature of Agent)



United Life Insurance Company

P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

NOTICES TO APPLICANTS

AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United 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. 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, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from the proposed insured(s), MIB will arrange disclosure of any information it may have on file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

United Life Insurance Company or its reinsurers may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at www.mib.com.



APPLICATION FOR LIFE INSURANCE

| PROPOSED INSURED A | PROPOSED INSURED B (Other insured) |
|--|--|
| Name _____ | Name _____ |
| Street Address _____ | Address _____ |
| City _____ State _____ Zip _____ | City _____ State _____ Zip _____ |
| Soc.Sec. # _____ U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No | SS# _____ U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of Birth _____ Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female | D.O.B. _____ Age _____ <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Phone _____ | Home Phone _____ |
| Driver's License # _____ | Driver's License # _____ |
| Occupation _____ Employer _____ | Occupation _____ Employer _____ |
| Work Phone _____ | Work Phone _____ |
| Other Life Insurance in force? <input type="checkbox"/> Yes <input type="checkbox"/> No Total Amt. \$ _____ | <input type="checkbox"/> yes <input type="checkbox"/> no \$ _____ |
| Have you smoked cigarettes in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Used any tobacco/nicotine products in the past 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> yes <input type="checkbox"/> no |

RATE CLASS

Standard (Cigarette smoker)
 Select (No cigarettes for 12 months, other tobacco acceptable)
 Preferred (Minimum \$100,000 face amount. **NOT available for SPWL.** No tobacco or nicotine products for 24 months.)

Owner (if different than insured) _____ Date of Birth _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

Relationship to the insured _____ Individual Corp LLC Partnership Other

Tax ID/SS # _____ U.S. Citizen Yes No

Contingent Owner (Required if proposed insured is a minor) _____

Payor Name (if different than owner) _____ Tax ID/SS Number _____

Billing Address _____ City _____ State _____ Zip _____ U.S. Citizen Yes No

FACE AMOUNT \$ _____
 (\$1,000,000+, complete Large Amt. Supplement)

PLAN

(1) **Uni-3*** Level Increasing
 Cost of Living

(2) **Whole Life**

(3) **5-Pay Whole Life** **10-Pay Whole Life**
 20-Pay Whole Life

(4) **Single Premium Whole Life**
 Guaranteed Ins. Option \$ _____
 Number of Options (1-5) _____
 Final Total Benefit \$ _____

(5) **Term Renewable & Convertible Term**
 Annual* 5-Yr.* 10-Yr.* 20-Yr.

*** Submit NAIC compliant illustration**

| RIDERS (by plan number) | Proposed Insured A | Proposed Insured B |
|---|------------------------------|--|
| <input type="checkbox"/> Other Insured Rider (1, 5) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Other Insured 20-Year Term (1, 2) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Accidental Death (1, 2, 5) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Disability Waiver (1, 2, 3, 5) <input type="checkbox"/> Yes | <input type="checkbox"/> Yes | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Disability Income 2-Year Limited Benefit (1, 2, 5) | \$ _____ | \$ _____ |
| <input type="checkbox"/> Disability Income to 65 <input type="checkbox"/> 30 day <input type="checkbox"/> 180 day (1, 2, 5) | \$ _____ | <input type="checkbox"/> 30 day <input type="checkbox"/> 180 day |

For DI coverage complete earnings on page 3.

RIDERS Available to Insured A only

| | |
|--|----------|
| <input type="checkbox"/> Additional Term Insurance (1) | \$ _____ |
| <input type="checkbox"/> Qualified Care Accelerated Death Benefit (1) | \$ _____ |
| <input type="checkbox"/> 20-Year Additional Term Ins. (1, 2) | \$ _____ |
| <input type="checkbox"/> UNI-3 Scheduled Increase Option (1) | \$ _____ |
| <input type="checkbox"/> Whole Life Guaranteed Insurability Option (2) | \$ _____ |
| <input type="checkbox"/> Children's Term Rider (1, 2, 5) See page 3. | \$ _____ |

Premium/Payment Mode

Planned 1st Yr. or **Annual Premium** \$ _____ **Bank Withdrawal (EFT)** Draft Date _____

Additional lump sum \$ _____ Mo Qrtly (**Attach voided check**)

Cash with app \$ _____ Please draft initial premium upon receipt of this application

1035(a) Exchange? Yes No COD **Mail Bill to payor:** Mo Qrtly SA Ann. or Single Prem. Paymt

List Bill Mo Qrtly SA Ann. If existing List Bill # AA _____

"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 or may be guilty of a crime and may be subject to fines and confinement in prison."

When we use the words “you” or “your” in this application, we mean Proposed Insured A or Proposed Insured B.

MEDICAL

Proposed Insured A **Proposed Insured B**

1. (A) Ht. _____ ft. _____ in. Wt. _____ (B) Ht _____ ft. _____ in. Wt. _____

2. Provide the name, address and phone number of your personal physician along with the date and reason last seen.

Dr. Name _____ Phone _____

Address _____

Date and reason last seen: _____

- | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 3. Have you ever applied for or been examined for life, accident or health insurance that was declined or modified as to rate or amount? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had or been told by a medical practitioner that you have the following: | | | | |
| A. Respiratory or lung disease, brain, nervous or mental disease, depression or anxiety, seizures or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Liver disease, colitis, diabetes, sugar in urine, cancer, tumor, disease of the prostate, kidney or urinary tract? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. High blood pressure, chest pain, heart disease, arrhythmia, stroke or other cardiovascular disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Back, bone or joint pain, arthritis, Alzheimer’s or Parkinson’s disease, muscular disease or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Alcohol or drug problems? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Chronic diarrhea, abdominal disease, blood, gland, spleen or skin disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been diagnosed or treated by a medical professional for an immune deficiency disorder, HIV, AIDS or ARC? (In Wisconsin, the reporting of HIV tests is limited to the positive results of FDA licensed tests, and AIDS tests results obtained at anonymous counseling and testing sites are confidential and need not be disclosed)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past five years have you used or do you now use barbiturates, amphetamines, narcotics, hallucinogens, marijuana, cocaine or any prescription drug except by physician’s prescription?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you taken any prescription medication during the last 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Any other accident, injury, operation or medical attention within the past five years not stated above? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been unable to work during the past three years due to illness or accident? (Disregard minor non-recurring illnesses.)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. During the past three years have you been charged with three or more moving vehicle violations or during the past five years been convicted of a DWI or DUI? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you taken any aerial flight other than as a fare-paying passenger on a commercial airline?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you participate in any hazardous avocation, occupation or sport? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you been convicted of or pled guilty or no contest to a felony in the past ten years?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you had a parent or sibling die prior to age 60 due to heart disease, diabetes or cancer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you intend to travel outside the United States for reasons other than recreational purposes?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have existing insurance or annuity contracts with this or any other company? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Is this insurance intended to replace existing insurance or annuity with this or any other company? .. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If “yes” to either question 16 or 17, complete the replacement form as required by state law and submit it with this application.

Explain any “YES” answers to questions 1-15. Provide details, dates, diagnosis, reason for prescriptions, etc.

BENEFICIARY DESIGNATION (will be Revocable and Per Stirpes if not indicated.)

PER STIRPES—if a named beneficiary dies before the insured, proceeds will be paid to the surviving direct descendants of that beneficiary.

PER CAPITA—if named beneficiary dies before the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

| PROPOSED INSURED A | PROPOSED INSURED B (OTHER INSURED RIDER) |
|---|---|
| Primary <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ | Primary <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ |
| Contingent <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ | Contingent <input type="checkbox"/> Revocable or <input type="checkbox"/> Irrevocable <input type="checkbox"/> Per Stirpes or <input type="checkbox"/> Per Capita 1. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ 2. Name _____ Relationship _____ SS# _____ Birthday _____ Address _____ |

ASSIGNMENT Is this policy assigned? Yes No

If yes, must attach a completed assignment form in order for assignment to be effective for this policy.

APPLICATION FOR CHILDREN'S COVERAGE—Children of the proposed insured who have not reached their 19th birthday

| Name | DOB | Injury, illness or history of medical problems within the past 5 yrs.? |
|-------|-------|--|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Have any of these children applied or been examined for life, accident or health insurance that was declined or modified as to rate or amount? Yes No If yes, give details.

Provide doctor's name and address. _____

DISABILITY INCOME BENEFITS (Complete only if applying for over \$500 in DI benefits)

Other disability insurance in force? (A) Yes No
 (B) Yes No

If yes, please provide details and identify by A or B.

| Monthly Benefit | Benefit Period | Company | Statement of Earnings |
|-----------------|----------------|---------|--------------------------------------|
| _____ | _____ | _____ | Earnings last year (A) \$ _____ |
| _____ | _____ | _____ | (B) \$ _____ |
| _____ | _____ | _____ | Earnings for prior year (A) \$ _____ |
| _____ | _____ | _____ | (B) \$ _____ |

IRS Taxpayer Certification

Under penalties of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

Medical Authorization

I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, insurance support organization, employer, or the Medical Information Bureau, Inc., to give United Life Insurance Company all information from the past 10 years that it holds, that pertains to medical consultations, treatments, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. I authorize United Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. The MIB is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This Authorization shall be in force for 24 months following the date of my signature, except in Arizona, where the authorization to disclose HIV related information shall be in force for 180 days. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at 118 Second Avenue SE, Cedar Rapids, Iowa 52407. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United Life 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 of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United Life 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 and I agree that a photocopy of this Authorization shall be as valid as the original.

Acknowledgement

I (we) have read this application in its entirety. I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.

City and State where signed _____ Date _____

X _____

SIGNATURE OF PROPOSED INSURED A
(or parent if Proposed Insured is a minor)

X _____

SIGNATURE OF PROPOSED INSURED B
(or parent if Proposed Insured is a minor)

X _____

SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED A

X _____

I, the **AGENT**, certify that I have used only insurer-approved or provided sales material. I also certify that I have left a copy of all sales material, replacement forms and disclosures with the applicant.

Are there existing life insurance or annuity contracts on the life of the insured(s)? Yes No

Is this policy intended to replace existing insurance or annuity with this or any other company? Yes No

SIGNATURE OF AGENT

AGENT'S PRINTED NAME

AGENCY NAME AGENCY NUMBER %

AGENCY NAME AGENCY NUMBER %

Date _____



United Life Insurance Company
P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

CONDITIONAL RECEIPT

AGENT: VALID ONLY WHEN ONE MONTH PREMIUM HAS BEEN COLLECTED

Unless every condition specified in Paragraph "First" below is fulfilled exactly, no insurance will become effective prior to Policy Delivery. No agent of the Company may alter or waive any conditions.

Received from _____ this _____ day of _____, 20____
the sum of \$_____ in connection with this application for life insurance to United Life Insurance Company. The application bears the same date as this receipt. (Checks must be payable to United Life Insurance Company.)

All premium checks must be made payable to the insurance company. Do not make the check payable to the agent or leave the payee blank.

Type of Policy applied for: _____ (Generic Name)

FIRST. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery.

- (a) the amount of premium taken with the application must be at least equal to the amount of one full monthly premium for the amount of insurance which may become effective prior to policy delivery; and
- (b) all medical examinations, tests, electrocardiograms required by the Company must be completed within 60 days from the date of the application; and
- (c) the Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards for the plan and for the amount applied for without modification and at the rate of premium paid; and
- (d) with respect to any life insurance applied for the Proposed Insureds must be in good health on the Effective Date.

Then the insurance as applied for in an amount not exceeding \$100,000 will become effective as of the latest of: (a) the date of the application, or (b) the date of completion of all medical examinations, tests, and electrocardiograms required by the Company or (c) the Date of Issue, if any, requested on the application.

SECOND. Limits Provision:

The maximum amount of insurance which may become effective prior to policy delivery shall not exceed a total of \$100,000 for this and any other applications pending with this Company.

THIRD. Return of Premiums Paid.

If one or more of the conditions in paragraph "FIRST" have not been fulfilled exactly, there shall be no liability on the part of the Company except to return Premiums paid.

(Signature of Agent)



United Life Insurance Company

P.O. Box 73909 Cedar Rapids, Iowa 52407-3909

NOTICES TO APPLICANTS

AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United 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. 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, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from the proposed insured(s), MIB will arrange disclosure of any information it may have on file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

United Life Insurance Company or its reinsurers may also release information in their file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at www.mib.com.