

**State:** Arkansas **Filing Company:** United of Omaha Life Insurance Company  
**TOI/Sub-TOI:** L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life  
**Product Name:** 2012 Final Expense Application -D389LAR12A  
**Project Name/Number:** 2012 Final Expense Application/D389LAR12A

## Filing at a Glance

Company: United of Omaha Life Insurance Company  
Product Name: 2012 Final Expense Application -D389LAR12A  
State: Arkansas  
TOI: L071 Individual Life - Whole  
Sub-TOI: L071.101 Fixed/Indeterminate Premium - Single Life  
Filing Type: Form  
Date Submitted: 12/18/2012  
SERFF Tr Num: MUTM-128814878  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: WANDA HILL  
  
Implementation: On Approval  
Date Requested:  
Author(s): Wanda Hill, Brandi Lashley, Kim Meyerring, Mary Gregg, Kryisia Gannon, Ellen Cochrane, Kendra Saylor  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 01/02/2013  
Disposition Status: Approved-Closed  
Implementation Date:  
  
State Filing Description:

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**TOI/Sub-TOI:** L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life  
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## General Information

Project Name: 2012 Final Expense Application  
Project Number: D389LAR12A  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 01/02/2013  
State Status Changed: 01/02/2013  
Created By: Ellen Cochrane  
Corresponding Filing Tracking Number:

Deemer Date:  
Submitted By: Ellen Cochrane

Filing Description:  
NAIC 261-69868

Individual Life Insurance  
D389LAR12A Individual Whole Life Application

I am submitting the attached whole life application for review and approval. This form is new and will not replace any previously filed forms.

The application will be used with individual whole life policies D343LNA12P and D344LNA12P both of which were previously approved by your Department on July 5, 2012.

Independent brokers and career agents will use this application to sell policies D343LNA12P and D344LNA12P in the general insurance market. This form will use simplified underwriting. Policy D343LNA12P will be offered if an applicant answers "No" to all of the underwriting questions. Policy D344LNA12P will be offered if an applicant answers "Yes" to any of the underwriting questions in Part Two of the application. Neither policy will be offered if an applicant answers "Yes" to any of the underwriting questions in Part One of the application.

The required filing materials are attached.

Your review and approval of this submission will be greatly appreciated. Please contact me with any questions or concerns.

Sincerely,

Wanda Hill  
Senior Product and Advertising Compliance Analyst  
Corporate Compliance and Ethics Division  
Phone: 402-351-3440 (Collect)  
Fax: 402-351-5298  
Email: wanda.hill@mutualofomaha.com

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## Company and Contact

### Filing Contact Information

Wanda Hill, Senior Policy Drafting and Regulatory Specialist  
 wanda.hill@mutualofomaha.com  
 Mutual of Omaha 402-351-3440 [Phone]  
 Mutual of Omaha Plaza 402-351-5298 [FAX]  
 Omaha, NE 68175

### Filing Company Information

United of Omaha Life Insurance Company	CoCode: 69868	State of Domicile: Nebraska
Mutual of Omaha Plaza	Group Code: 261	Company Type: Life Insurance
Omaha, NE 68175	Group Name:	State ID Number:
(402) 351-6910 ext. [Phone]	FEIN Number: 47-0322111	

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

Company	Amount	Date Processed	Transaction #
United of Omaha Life Insurance Company	\$50.00	12/18/2012	65864846

SERFF Tracking #:

MUTM-128814878

State Tracking #:

Company Tracking #:

WANDA HILL

State:

Arkansas

Filing Company:

United of Omaha Life Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/02/2013	01/02/2013

SERFF Tracking #:

MUTM-128814878

State Tracking #:

Company Tracking #:

WANDA HILL

State:

Arkansas

Filing Company:

United of Omaha Life Insurance Company

TOI/Sub-TOI:

L071 Individual Life - Whole/L071.101 Fixed/Indeterminate Premium - Single Life

Product Name:

2012 Final Expense Application -D389LAR12A

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2012 Final Expense Application/D389LAR12A

## Disposition

Disposition Date: 01/02/2013

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	AR Credit Card Certification		Yes
Supporting Document	Memorandum of Variability		Yes
Form	Individual Whole Life Application		Yes

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## Form Schedule

Lead Form Number: D389LAR12A

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Individual Whole Life Application	D389LAR12A	AEF	Initial			D389LAR12A .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

# UNITED OF OMAHA LIFE INSURANCE COMPANY <sup>1</sup>

A MUTUAL OF OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175

Home Office Use Only



## Application for Individual Life Insurance [Marketing Name] <sup>2</sup>

PROPOSED INSURED					
Name (First, Middle Initial, Last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Social Security No.
Home Address (Street, City, State, Zip)			State of Birth	Date of Birth	Age
Phone No.	E-mail	<sup>3</sup> [Driver's License No.]	<sup>3</sup> [Driver's License State]		
Are you a legal resident of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (if "No", you are not eligible for coverage)			In the past 12 months, has the Proposed Insured used any form of tobacco or nicotine replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
OWNER (Complete only if Owner/Applicant is different from Proposed Insured)					
Name of Policyowner (First, Middle Initial, Last)			Relationship to Proposed insured		
Policyowner Address (Street, City, State, Zip)			Phone No.	Social Security No.	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Age	E-mail	Citizenship Country	
UNDERWRITING					
IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.					
<b>1. Is the Proposed Insured currently:</b> <b>(a)</b> bedridden or confined to any hospital, nursing home, long-term care facility or skilled nursing facility; or receiving or been advised to receive care in a nursing home, hospice care, or home health care? . . . . <b>(b)</b> requiring assistance with activities of daily living such as taking medications, bathing, dressing, eating, toileting, getting in and out of a chair or bed, or control of bowel or bladder problems? . . . . . <b>(c)</b> requiring any of the following (other than for fractures, bone or joint surgery, including replacement): wheelchair, electric scooter, or oxygen equipment to assist breathing (excluding use for sleep apnea)? . . . . .					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2. Has the Proposed Insured ever been:</b> <b>(a)</b> diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? . . . . . <b>(b)</b> diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Quadriplegia, Paraplegia, Down's Syndrome, mental incapacity, congestive heart failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type? . . . . . <b>(c)</b> diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed with End Stage Renal Disease or requiring dialysis? . . . . . <b>(d)</b> advised to receive or have received an organ or bone marrow transplant? . . . . . <b>(e)</b> diagnosed by a physician or health care provider as having a terminal medical condition that is expected to result in death within the next twelve (12) months? . . . . .					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>3. In the past 12 months, has the Proposed Insured been:</b> <b>(a)</b> advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known? . . . . . <b>(b)</b> diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind? . .					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4. In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for any form of cancer (except basal or squamous cell skin cancer)? . . . . .</b>					<input type="checkbox"/> Yes <input type="checkbox"/> No

<p><b>5.</b> Has the Proposed Insured <b>ever</b> (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:</p> <p><b>(a)</b> Diabetes before age 50 or diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)? .....</p> <p><b>(b)</b> Hepatitis C? .....</p> <p><b>(c)</b> Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis? .....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>6. In the past 4 years</b>, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:</p> <p><b>(a)</b> Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)? . . .</p> <p><b>(b)</b> Chronic Kidney Disease, Systemic Lupus or Scleroderma? .....</p> <p><b>(c)</b> Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis? .....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>7. In the past 2 years</b>, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:</p> <p><b>(a)</b> Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement? .....</p> <p><b>(b)</b> Stroke or Transient Ischemic Attack (TIA)? .....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>8. In the past 2 years</b>, has the Proposed Insured:</p> <p><b>(a)</b> been convicted of, incarcerated for or currently awaiting trial for a felony? .....</p> <p><b>(b)</b> been treated for or advised to have treatment for alcohol or drug abuse or convicted more than once of reckless driving or driving under the influence of drugs or alcohol? .....</p> <p><b>(c)</b> used unlawful drugs in any form or abused or misused prescription drugs? .....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>9. In the past 2 years</b>, has the Proposed Insured been hospitalized by a physician or health care provider for any mental or nervous disorder? .....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>10. In the past 12 months</b>, has the Proposed Insured consulted a physician for chronic cough, <u>unexplained</u> weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding? .....</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

**OPTIONAL COMMENTS (Not Required)** - Provide any additional information available.

Question Number	Details to Underwriting Questions (Diagnosis, Dates, Durations, Medications, Dosages)

**PLAN INFORMATION**

Plan:  
 Level Benefit Product]  
Amount Applied For \$ \_\_\_\_\_

Rider:  
 Accidental Death Rider] 6

Payment Mode:  
 Annual]  Semiannual]  Quarterly]  Monthly (Automated Bank Account Withdrawal)]  Credit Card]  
Modal Premium \$ \_\_\_\_\_ Collected Premium \$ \_\_\_\_\_

**BENEFICIARY** (If more space is needed, list on a separate sheet)

Primary Beneficiary Relationship to Insured Date of Birth

Address Social Security No. Phone No.

Contingent Beneficiary Relationship to Insured Date of Birth

Address Social Security No. Phone No.

**OTHER COVERAGE INFORMATION**

- 1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company? .....  Yes  No
  - 2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with the company or any other company? .....  Yes  No
- If "Yes" to questions #1 or #2, please give details below. If more space is needed, list on a separate sheet.

Company	Proposed Insured	Face Amount	To be Replaced or Converted?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

**AGREEMENT**

- 1. The undersigned agree(s) that (a) all answers in this application are true and complete to the best of my knowledge and belief; (b) United of Omaha Life Insurance Company ("United of Omaha") will rely on these answers to determine insurability; and (c) incorrect or misleading answers may void this application and any issued policy effective the issue date.
- 2. The undersigned acknowledge(s) that United of Omaha may require medical records, an underwriting assessment, a medical examination, or other information.
- 3. The undersigned agree(s) that United of Omaha will not issue a policy as a result of this application unless (a) the Proposed Insured completes all medical examinations and tests required by United of Omaha; (b) United of Omaha receives any additional information requested for underwriting; and (c) the Proposed Insured is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the Proposed Insured or the Applicant (if other than the Proposed Insured) has subsequently accepted an offer by United of Omaha for coverage other than as applied for, according to the underwriting standards of United of Omaha then in force.
- 4. The undersigned agree(s) that this application does not provide temporary or interim insurance prior to policy issuance. If the undersigned has made an advance premium payment, undersigned agree(s) to the terms and conditions of the Conditional Receipt. The undersigned agree(s) that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. The undersigned acknowledge(s) that if this application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to the Proposed Insured or the Applicant (if other than the Proposed Insured), without interest. No insurance coverage will be in effect until United of Omaha (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
- 5. A completed and signed application will become part of the Proposed Insured's policy or the Applicant's policy (if other than the Proposed Insured).
- 6. The undersigned acknowledge(s) that no producer can (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I have received the MIB, Inc. Pre-Notice, the Notice of Information Practices and a Life Insurance Buyer's Guide before completing this application.

I approve the answers to the questions in this application as recorded.

**I have read and understand the Authorization to Receive Information form and Disclose Information to MIB, Inc. and the Agreement Section.**

Signed at: \_\_\_\_\_  
City State

Date: \_\_\_\_\_

Signature of Proposed Insured

Date: \_\_\_\_\_

Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)

**Producer Statement:**

By signing below, I/we, the Producer(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

Do you, the Producer(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy or annuity contract in force with the company or any other company? .....  Yes  No

Has the Proposed Insured informed you, the Producer(s), that he/she has any pending applications or existing life insurance or annuity contracts with the company or any other company? .....  Yes  No

**(If either question is answered "Yes," fulfill all state and company requirements.)**

Are you related to the Proposed Insured or Owner? .....  Yes  No

**If "Yes," state relationship** \_\_\_\_\_

How long have you known the Proposed Insured? \_\_\_\_\_

How long have you known the Proposed Owner? \_\_\_\_\_

Signature of Producer #1 Producer E-mail Production Number Date

Signature of Producer #2 Producer E-mail Production Number Date

Print Producer #1 Name Print Producer #2 Name Agency Name

**SERFF Tracking #:**

MUTM-128814878

**State Tracking #:****Company Tracking #:**

WANDA HILL

**State:**

Arkansas

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## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
READCERT United.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	AR Credit Card Certification		
Comments:			
Attachment(s):			
AR Credit Card Cert.pdf			

		<b>Item Status:</b>	<b>Status Date:</b>
Satisfied - Item:	Memorandum of Variability		
Comments:			
Attachment(s):			
D389LAR12A_Memo of Variability.pdf			

**UNITED OF OMAHA LIFE INSURANCE COMPANY  
OMAHA, NEBRASKA**

**READABILITY CERTIFICATION**

Date: December 18, 2012

United of Omaha Life Insurance Company certifies that the Flesch Readability Score for the following forms is (see attached list if no forms are shown):

<u>Form</u>	<u>Flesch Score</u>
D389LAR12A	50.0*

\*When scored with the policy with which it will be used.



Daniel J. Kennelly  
Vice President, Chief Compliance and Ethics Officer  
United of Omaha Life Insurance Company

# Arkansas Insurance Department

Mike Huckabee  
Governor



Julie Benafield Bowman  
Commissioner

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

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

  
SIGNATURE

12/18/2012  
DATE

Mutual of Omaha Insurance Company  
COMPANY

CC-1

**Memorandum of Variability**  
**Explanation of Variable Statements and Fields**  
**For United of Omaha Life Insurance Company**  
**Application Form**  
**D389LAR12A**

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in **RED**. The explanations below follow the order in which the variable fields appear in the form.

Other than noted below, no changes will be made in the wording shown on the app. Variability denotes whether the language will appear or be omitted.

<i>Variable Statements/Fields</i>	<i>How or When Used</i>
1 [Home Office Use Only box]	This is used for internal coding and identification purposes.
2 <b>Application for Individual Life Insurance</b> [Marketing Name]	Will print depending on marketing and printing layout. Variable to allow Marketing Name to include a trademark or registered name.
3 [Driver's License No.] [Driver's License State]	Will print depending on marketing layout.
4 [Optional Comments (Not Required) Table]	Will print depending on marketing layout.
5 Plan: [ <input type="checkbox"/> Level Benefit Product]	Variable to allow for product name change.
6 Rider: [ <input type="checkbox"/> Accidental Death Rider]	A combination will print depending on riders offered and marketing and printing layout. Riders may appear or be omitted. Also variable to allow for additional riders.
7 Payment Mode: [ <input type="checkbox"/> Annual] [ <input type="checkbox"/> Semiannual] [ <input type="checkbox"/> Quarterly] [ <input type="checkbox"/> Monthly (Automated Bank Account Withdrawal)] [ <input type="checkbox"/> Credit Card]	A combination will print depending on payment method offered and marketing and printing layout. Payment modes may appear or be omitted. Credit Card is variable to allow the option of Annual, Semiannual, Quarterly or Monthly.
8 [Address    Social Security No.    Phone No. ]	Will print depending on state regulations.