UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL of OMAHA COMPANY

# LIFE APPLICATION SUBMISSION FORM

**Send to: Individual Life Underwriting**
**United of Omaha Life Insurance Company**
**9330 State Hwy 133**
**Blair, NE 68008**

Comments: * Example Term Life Express *

| Name of Insured |
|---|
| John D Doe |

| Name of Agent | Production Number | Phone Number | Email Address |
|---|---|---|---|
| Cody M. Beck | 0555555 | 937-307-2089 | Cbeck@equisfinancial.com |

| Next Highest Upline | Production Number | Phone Number | Email Address |
|---|---|---|---|
| Equis Financial | 0694399 | 937 832 3100 | newbusiness@equisfinancial.com |

Please list any underwriting requirements that have already been ordered by the agent or Master General Agent/Broker General Agent.

L7421

# UNITED OF OMAHA LIFE INSURANCE COMPANY

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

## INDIVIDUAL LIFE INSURANCE APPLICATION

### PROPOSED INSURED

| Name (First, Middle Initial, Last) | Social Security No. | Sex | Height | Weight | Annual Income |
|---|---|---|---|---|---|
| John D Doe | 222-22-2222 | M | 5'10" | 220 | 60,000 |

| Home Address (Street, City, State, ZIP) | State of Birth | Date of Birth |
|---|---|---|
| 895 Herr St Englewood OH 45322 | OH | 11-22-1960 |

| Best Time to Call | Phone Number | E-mail |
|---|---|---|
| 4-8 pm | (937) 832-1378 | Johndoe@gmail.com |

| Driver's License No. | Driver's License State | Occupation/Duties | Employer |
|---|---|---|---|
| RW111111 | OH | Electrician | Chapel |

U.S. Citizen?.... ☒ **Yes** ☐ **No** (If "No," complete the Foreign National and Foreign Travel questionnaire)

**In the past 12 months,** has the Proposed Insured used any form of tobacco, or any form of nicotine replacement therapy? ☐ **Yes** ☒ **No**

### PLAN INFORMATION

**TERM LIFE:**

- ☐ 30-Year Level Term Life with 5 Year Guarantee
- ☐ 20-Year Level Term Life with 5 Year Guarantee
- ☐ 30-Year Level Term Life with 30 Year Guarantee
- ☒ 20-Year Level Term Life with 20 Year Guarantee
- ☐ 15-Year Level Term Life with 15 Year Guarantee
- ☐ 10-Year Level Term Life with 10 Year Guarantee

Term Life Express Amount of Insurance Applied for

$ 100,000

Return of Premium..... ☐ **Yes**
(only available for 20-Year and 30-Year Guarantee)

**TERM RIDERS: (COMPLETE SUPPLEMENTAL APPLICATIONS IF APPLYING FOR A DISABILITY RIDER OR THE CHILDREN'S RIDER)**

- ☐ Disability Income Rider (not available with Return of Premium): ☐ 18 months ☐ 30 months
  Disability Income Rider Monthly Benefit $_____
- ☐ Disability Waiver of Premium
- ☐ Dependent Children's Rider Benefit Amount of Insurance Applied for: ☐ $5,000 ☐ $10,000
- ☐ Accidental Death Benefit Rider Amount of Insurance Applied for $ _____

**PERMANENT LIFE:**

- ☐ Guaranteed Universal Life Express Amount of Insurance Applied for $_____

**PERMANENT LIFE RIDERS: (COMPLETE SUPPLEMENTAL APPLICATIONS IF APPLYING FOR A DISABILITY RIDER OR THE CHILDREN'S RIDER)**

- ☐ Disability Waiver of Policy Charges Rider ☐ Disability Continuation of Planned Premium Rider Amount $_____
- ☐ Dependent Children's Rider Benefit Amount of Insurance Applied for: ☐ $5,000 ☐ $10,000
- ☐ Accidental Death Benefit Rider Amount of Insurance Applied for $ _____

**PAYMENT MODE** ☐ Annual ☐ Semiannual ☐ Quarterly ☒ Monthly Bank Draft ☐ Other _____

Modal Premium $ 99.24 Collected Premium $ draft

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### OWNER (Complete Policyowner Information if Proposed Insured is not the Policyowner)

| Name of Policyowner (First, Middle Initial, Last) | Relationship to Proposed Insured | Date of Birth | Phone No. |
|---|---|---|---|
| | | | |

| Policyowner Address (Street, City, State, ZIP) | Social Security No./Tax ID | Citizenship Country |
|---|---|---|
| | | |

## BENEFICIARY

| Primary Beneficiary | % of Proceeds | Relationship to Insured | Date of Birth |
|---|---|---|---|
| Mary A Doe | 100% | Wife | 12-25-1960 |
| **Contingent Beneficiary** | **% of Proceeds** | **Relationship to Insured** | **Date of Birth** |
| | | | |

If more space is needed, provide information in Comments section.

## OTHER COVERAGE INFORMATION

1. List below all life insurance policies and/or annuity contracts on any person proposed for insurance that are now pending, are now in force (including any that have been assigned or sold), or that have terminated in the last 13 months. If none, check the following box ..... or ..... ☐ **None**
2. Has the Proposed Insured had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? ..... ☐ **Yes** ☒ **No**

**The Producer shall comply with any additional state and/or company replacement requirements.**

| Company | Face Amount | ADB Amount | To Be Replaced or Converted? |
|---|---|---|---|
| State Farm | 100,000 | — | ☐ Yes ☒ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

3. **In the past 10 years,** has the Proposed Insured been declined for life insurance coverage? ..... ☐ **Yes** ☒ **No**
4. Has the Proposed Insured been offered cash or any other consideration for obtaining this policy? ..... ☐ **Yes** ☒ **No**
5. Are you planning to enter into a finance arrangement to pay any premium payments due under this policy? ..... ☐ **Yes** ☒ **No**
6. Do you intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? ..... ☐ **Yes** ☒ **No**

**If "Yes" to questions 3, 4, 5 or 6 provide information in Comments section.**

## COMMENTS

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

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## UNDERWRITING

| **If the Proposed Insured answers "Yes" to questions 1 through 7 in this section, that person is not eligible for coverage under this application.** | Proposed Insured |
|---|---|
| **1.** Has the Proposed Insured ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? | ☐ Yes ☒ No |
| **2.** Has the Proposed Insured **ever** (i) been diagnosed with, or (ii) received care or treatment for, or (iii) been advised by a member of the medical profession to seek treatment for, or (iv) consulted with a health care provider regarding: | |
| **(a)** Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease with Repair or Replacement, Cardiomyopathy, Congestive Heart Failure, Congenital Heart Disease, Stroke, Transient Ischemic Attack (TIA)/mini-stroke, abnormal heart rhythm, or Cerebral, Aortic or Thoracic Aneurysm? | ☐ Yes ☒ No |
| **(b)** Chronic Lung Disease (except mild Asthma), including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis? | ☐ Yes ☒ No |
| **(c)** Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Sickle Cell Anemia, Lou Gehrig's Disease (ALS), Muscular Dystrophy, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down's Syndrome, Autism, mental incapacity, or any other disease of the central nervous system? | ☐ Yes ☒ No |
| **(d)** Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C? | ☐ Yes ☒ No |
| **(e)** Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell or squamous cell skin cancer)? | ☐ Yes ☒ No |
| **(f)** Systemic Lupus or Scleroderma? | ☐ Yes ☒ No |
| **(g)** an organ transplant? | ☐ Yes ☒ No |
| **3.** Has the Proposed Insured **currently or within the past 12 months:** | |
| **(a)** required the assistance of another person or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems? | ☐ Yes ☒ No |
| **(b)** received, or been advised by a member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services or is the Proposed Insured currently confined to any hospital or other medical facility? | ☐ Yes ☒ No |
| **(c)** used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? | ☐ Yes ☒ No |
| **4. In the past 12 months**, has the Proposed Insured: | |
| **(a)** been advised by a member of the medical profession to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS , treatment, or other procedure which has not been done? | ☐ Yes ☒ No |
| **(b)** consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds (other than due to diet or exercise), fatigue or unexplained gastrointestinal bleeding? | ☐ Yes ☒ No |
| **5. In the next 2 years**, will the Proposed Insured engage in any motor sports racing, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing? | ☐ Yes ☒ No |
| **6. In the past 10 years**, has the Proposed Insured: | |
| **(a)** used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a member of the medical profession? | ☐ Yes ☒ No |
| **(b)** used or been convicted of possession of unlawful drugs or used prescription drugs other than as prescribed in any form? | ☐ Yes ☒ No |
| **(c)** been convicted of or currently awaiting trial for a felony? | ☐ Yes ☒ No |
| **(d)** been hospitalized for high blood pressure or any mental or nervous disorder? | ☐ Yes ☒ No |
| **7. In the past 5 years**, has the Proposed Insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving or been convicted of four or more moving violations? | ☐ Yes ☒ No |

## UNDERWRITING CONTINUED

| | Proposed Insured |
|---|---|
| **8.** Has the Proposed Insured ever (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for: | |
| **(a)** Diabetes? | ☐ Yes ☒ No |
| **(b)** Diabetes before age 50 other than Gestational Diabetes? | ☐ Yes ☒ No |
| **(c)** Diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)? | ☐ Yes ☒ No |
| **9. In the past 12 months,** has the Proposed Insured applied for or received disability, hospital or medical benefits from any insurance company, government, employer, or other source (other than for maternity, fractures, spinal or back disorders or hip or knee replacement)? | ☐ Yes ☒ No |
| **10. In the past 5 years,** has the Proposed Insured consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition (other than for routine physical checkups, eye, employment or FAA examinations)? | ☐ Yes ☒ No |

**If answered "Yes" to questions 8-10, please list details below. If more space is needed, use the Comments section in Part 1.**

| Person Proposed for Insurance | Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type) | Month and Year | Duration | Name, Address, ZIP and Telephone Number of Hospital and/or Attending Physician |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

~~**11.** If the Proposed Insured is age 61 or older with a face amount greater than $250,000, provide the name and address of personal physician.~~

## AUTHORIZATION AND AGREEMENT

**Authorization:** I authorize any medical provider, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical care facility, MIB, Inc. (MIB), state department of motor vehicles and other entities processing motor vehicle records, insurance companies or consumer reporting agencies to release information about me or my health, such as, medical history, including the presence of HIV infection, AIDS or ARC, mental or physical condition, prescription drug records, drug or alcohol use, driving record or insurance claims information, to United of Omaha Life Insurance Company ("United of Omaha"). The information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise. I also authorize United of Omaha to disclose information to MIB. I understand that my information received by MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations. This authorization is valid for 24 months from the date signed. I may refuse to sign this authorization but if I refuse, the insurance I am applying for will not be issued. I may revoke this authorization at any time by written notice to the address below. This revocation is limited to the extent that United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha to contest the issuance of the policy or a claim under the policy. I will receive a copy of this authorization.

**Agreement:** I represent the information above is true and complete. Any incorrect or misleading answers may void this application and any issued policy effective the issue date. Unless otherwise provided under a conditional receipt, I understand that no insurance shall take effect until all outstanding application requirements have been received, a policy is issued and the first premium is received by United of Omaha during the proposed insured's lifetime. The issue date of the policy will be the date shown on the policy, even though coverage may not become effective until a later date. You must immediately notify United of Omaha if there has been a change in the proposed insured's health or habits that will change any statement or answer to any question in the application as of the date the policy is delivered. No policy of any kind will be in effect if the proposed insured dies or is otherwise ineligible for the insurance for which they applied. No producer can waive or change any receipt or policy provision or agree to issue any policy.

**Fraud Warning:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at: Englewood (City) OH (State) Date 11-4-2015 (Mo Day Yr)

John D Doe
Signature of Proposed Insured Age 15 and Over

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

Signature of Parent or Guardian if Proposed is under Age 15

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# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

Mutual of Omaha

## PRODUCER STATEMENT

1. Has any person proposed for insurance informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? ..... ☒ **Yes** ☐ **No**
   **If "Yes," give name(s) of the person(s)** John Doe * Do not write company insurance is with *

2. Do you, the Producer(s), know or have reason to believe that the policy(ies) applied for has replaced or will replace any existing life insurance policies or annuity contracts? ..... ☐ **Yes** ☒ **No**

3. Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer's Guide and comply with all state and Company replacement requirements? ☒ **Yes** ☐ **No** **If "No," please explain** _____

4. I/We certify that, during an interview with the Proposed Insured, I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. ☒ **Yes** ☐ **No**
   **If "No," please explain** _____

5. I conducted said interview in person ☒ **Yes** ☐ **No** **If "No," please explain** _____

6. **(a)** Are you related to the Proposed Insured or Owner? ☐ **Yes** ☒ **No** **If "Yes," state relationship** _____

   **(b)** How long have you known the Proposed Insured? 1 day

   **(c)** How long have you known the proposed Owner? 1 day

7. Previous residence(s) of Proposed Insured for past five years.

| Address | From | To |
|---|---|---|
| | | |
| | | |
| | | |

Cody M. Beck — Signature of Producer #1 — 0555555 Production Number — 11-4-2015 Mo Day Yr

Signature of Producer #2 — Production Number — Mo Day Yr

Cody M. Beck
Print or Stamp Producer #1 Name

Print or Stamp Producer #2 Name

General Agent/General Manager Name

General Agent/General Manager Stamp



**PLEASE SUBMIT ALL PAGES**

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

## Producer's Report

**(Must be completed by the Producer who obtained the application on the Proposed Primary Insured named below.)**

1. Proposed Primary Insured Full Name John (First Name) D (Initial) Doe (Last Name)

2. Please Note: A recent mortgage is not required for issuance of this policy.

   Has the Proposed Insured purchased a home or refinanced a home within the last 2 years? ..... ☒ **Yes** ☐ **No**

   **If "Yes," then complete the remainder of Question 2**

   Approximate Mortgage Loan Amount $ 100,000

   Mortgage Loan Financial Institution Name Wright Patt Credit Union

3. Have you, the producer, observed or are you aware of any additional information that may affect the issuance of this policy? If "Yes," explain below ..... ☐ **Yes** ☒ **No**

# UNITED OF OMAHA LIFE INSURANCE COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600

## PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: John D Doe  Policy Number(s) if known: _____

**Complete this form only when authorizing a bank account withdrawal for premium payment.**

### PAYMENT INFORMATION

1. **Initial Monthly Premium Payment (select only one option)** Amount Quoted $ 99.24

   ☒ Draft premium immediately upon approval/issue

   ☐ Draft initial premium on or after: _____/_____/_____ (Please Note: If policy issue is after date selected, premium will be withdrawn on the policy issue date or receipt of delivery requirements)

   ☐ Check collected and mailed to Mutual of Omaha

   When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT AS STATED ABOVE. The first Withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. We **CANNOT** establish electronic payments from foreign banks.

2. **Ongoing Premium Payments**- Automated Bank Account Withdrawal (Monthly)

   Specify the date ongoing premiums will be withdrawn: (1st through the 28th of each month) _____

   Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

### PAYOR INFORMATION

Name of payor as shown on bank account: John D Doe  Social Security No. 222-22-2222

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation required)

☐ Employer  ☐ Living Trust

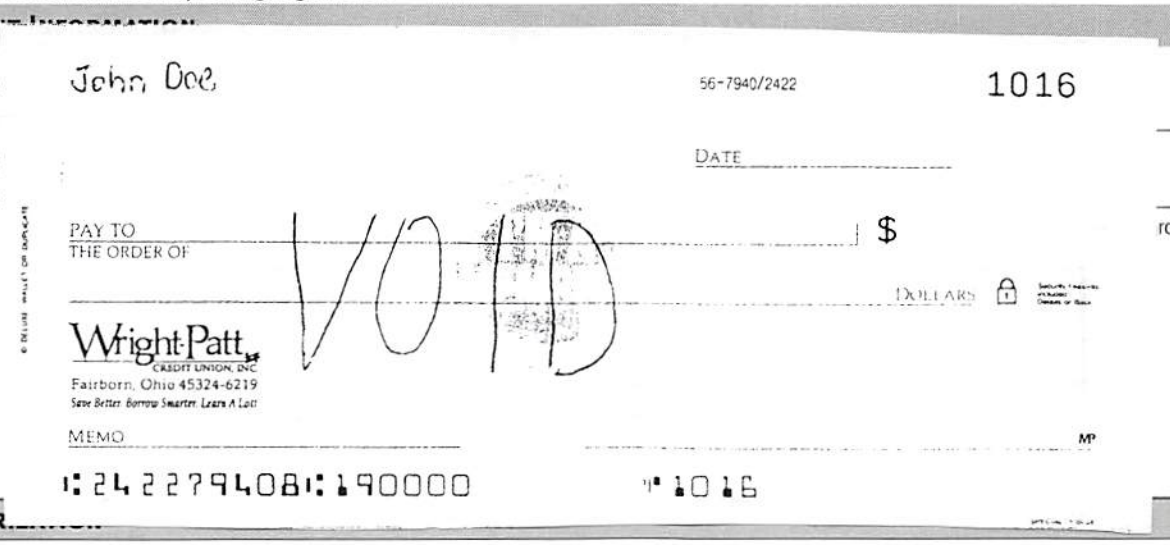
☐ Business owned by Proposed Insured/Insured or spouse  ☐ Other _____

☐ Power of Attorney or legal guardian

### ACCOUNT INFORMATION

1. Ac
2. Na
3. Co

Ba




rd numbers)

### AUTHOR...

I authorize United of Omaha Life Insurance Company ("United of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to United of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, United of Omaha may require written confirmation from me within 14 days after my verbal notice.

Date 11-4-2015 X John D Doe

Mo./Day/Yr.  Authorized Signature as Shown on Account

**UNITED OF OMAHA LIFE INSURANCE COMPANY**
A MUTUAL *of* OMAHA COMPANY

# ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

***The benefit received under any accelerated death benefit rider may be taxable. Receipt of the benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting an accelerated death benefit.***

## DISCLOSURE FOR TERM LIFE INSURANCE POLICIES

If you are applying for term life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium charge for the rider.

### BENEFIT DESCRIPTION

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 92% of the policy's death benefit.[1] A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 24 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness.

[1] *In* ***Indiana,*** 94%.

### EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay the accelerated death benefit, the policy and all its riders will terminate.

## DISCLOSURE FOR UNIVERSAL LIFE INSURANCE POLICIES

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider, the Accelerated Death Benefit for Chronic Illness Rider, and their effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the riders. There is no premium or cost of insurance for these riders.

### BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit. The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

A Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a $100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount rate will not be greater than 6%.

### BENEFIT DESCRIPTION - ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats and safety due to severe cognitive impairments.

The sum of all requested accelerations may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration. Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by an actuarial discount rate multiplied by the insured's life expectancy in years, a $100 charge, and the pro-rated amount of any outstanding loans.

### EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay any accelerated death benefit, the following will occur: (a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the death benefit; and (b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.

## Acknowledgment

I acknowledge receipt of this Disclosure Form

John D Doe — 11-4-2015

Applicant/Owner Signature — Date

I have provided this Disclosure Form to the Applicant

Cody Mo Beck — 11-4-2015

Producer Signature — Date

# CONDITIONAL RECEIPT ("RECEIPT")

United of Omaha Life Insurance Company ("United", "we"), Mutual of Omaha Plaza, Omaha, NE 68175

**IF ANY PROPOSED INSURED DIES WHILE COVERAGE UNDER THIS RECEIPT IS IN EFFECT, WE WILL PAY TO THE BENEFICIARY(IES) NAMED IN THE APPLICATION THE AMOUNT DESCRIBED IN THE SECTION BELOW ENTITLED "BENEFIT".**

**DATE OF RECEIPT:** 11-4-2015

**BENEFIT**

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) $100,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed $100,000.

**CONDITIONS**

Conditions under which a benefit may be payable under this Receipt prior to policy delivery:

1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and
2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and
3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and
4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.

If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.

**END DATE**

This Receipt and any coverage provided hereunder will **END** on the earliest of the following dates:

1 60 days from the date of this Receipt; or
2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 The date the Applicant/Owner withdraws the application for insurance.

**SIGNATURES**

This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.

I/We have read and received a copy of this Receipt and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.

John D Doe — Signature of Proposed Insured — Date: 11-4-2015

Signature of Other Proposed Insured — Date

Signature of Applicant/Owner (if other than Proposed Insured) — Date

Payment Method: Check ☐ Electronic Transaction Authorization ☒ Amount remitted/authorized $ 99.24

I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

Tony M Beck — Signature of Producer — Date: 11-4-2015

Signature of Producer — Date

THIS REPLACEMENT FORM REQUIRED IF APPLICANT/OWNER HAS ANY EXISTING LIFE OR ANNUITY CONTRACTS

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

## Important Notice: Replacement of Life Insurance or Annuities

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☒ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☒ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

| Insurer Name | Contract or Policy # | Insured or Annuitant | Replaced (R) or Financing (F) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because No Replacement

If you are replacing list below the form number(s) and brief description(s) of preprinted or electronic sales material which was presented or check "NONE" box if no sales material was used in this sale: ☒ NONE

(The agent must provide the applicant with a copy of all sales material used at time of application, including electronically presented sales material in printed form no later than the time of policy or contract delivery.)

or write what you used

I certify that the responses herein, to the best of my knowledge, are accurate.

| Applicant | Applicant B (if applicable) |
|---|---|
| Printed Name of Proposed Applicant/Owner: John O Doe | Printed Name of Proposed Applicant/Owner |
| Signature of Proposed Applicant/Owner: John O Doe | Signature of Proposed Applicant/Owner |
| Date: 11-4-2015 | Date |

Cody M. Beck — Agent's Signature

Cody M. Beck — Agent's Printed Name

11-4-2015 — Date

I do not want this notice read aloud to me. JD (Applicants must initial only if they do not want the notice read aloud.)