UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL of OMAHA COMPANY

Mutual of Omaha

LIFE APPLICATION SUBMISSION FORM

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

Comments: * Example Living Promise *

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.

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

OHIO – APPLICATION FOR LIFE INSURANCE

LIVING PROMISE PRODUCT – ONE BASE POLICY PER APPLICATION

✍ *Checklist for Submitting a Complete Application*

Please mail application and appropriate forms to: United of Omaha Life Insurance Company,
Attn: Individual Life Underwriting, 9330 State Hwy 133, Blair, NE 68008
FAX: 1-402-997-1800

☞ PLEASE CHOOSE THE PRECISE PLAN, RIDER, AND AMOUNT OF INSURANCE APPLIED FOR

☒ LEVEL BENEFIT PRODUCT:	❑ GRADED BENEFIT PRODUCT (IF AVAILABLE):
• Accelerated Death Benefit Rider • Accidental Death Benefit Rider (OPTIONAL)	• No Riders Available

APPLICATION SUBMISSION GUIDELINES

- ❑ Attach a cover letter or additional information as needed.
- ❑ Always submit the Producer Report page.
- ❑ Leave all applicable forms and Life Buyer's Guide with the Proposed Insured.
- ❑ All changes should be initialed by the Applicant/Owner.
- ❑ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

IMPORTANT FORMS

- ❑ Replacement Notice – if applicable, the client must sign and retain a copy for their records
- ❑ Payment Authorization – Complete this form if applicable
- ❑ Conditional Receipt – Complete ONLY if you accepted a check or electronic transaction authorization at time of application for the initial premium. **DO NOT** complete the Conditional Receipt if initial payment won't be collected until issue.
- ❑ Accelerated Benefit Rider Disclosure – The client must sign the Accelerated Benefit Rider Disclosure Form

Supplemental Applications, Forms, and Buyer's Guide:

- ***Buyer's Guide:*** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale.

UNITED OF OMAHA LIFE INSURANCE COMPANY

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

Mutual of Omaha

Application for Individual Life Insurance

PROPOSED INSURED

Name (First, Middle Initial, Last)	Sex	Height	Weight	Social Security No.
John D Doe	☒ Male ☐ Female	5'10"	220	222-22-2222

Home Address (Street, City, State, Zip)	State of Birth	Date of Birth	Age
895 Herr St Englewood OH 45322	OH	11-22-1960	54

Phone No.	E-mail	Driver's License No.	Driver's License State
(937) 832-1378	Johndoe@gmail.com	RW111111	OH

Are you a legal resident of the United States? ☒ **Yes** ☐ **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? ☐ **Yes** ☒ **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	Date of Birth	Age	E-mail	Citizenship Country
☐ Male ☐ Female				

UNDERWRITING

Part One **IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN PART ONE, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.**

1. Is the Proposed Insured currently:	
(a) 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?	☐ **Yes** ☒ **No**
(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?	☐ **Yes** ☒ **No**
(c) 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)?	☐ **Yes** ☒ **No**
2. Has the Proposed Insured **ever been**:	
(a) 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 heath care provider?	☐ **Yes** ☒ **No**
(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?	☐ **Yes** ☒ **No**
(c) diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed with End Stage Renal Disease or requiring dialysis?	☐ **Yes** ☒ **No**
(d) advised to receive or have received an organ or bone marrow transplant?	☐ **Yes** ☒ **No**
(e) 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?	☐ **Yes** ☒ **No**
3. In the past 12 months, has the Proposed Insured been:	
(a) 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?	☐ **Yes** ☒ **No**
(b) diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind?	☐ **Yes** ☒ **No**
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)?	☐ **Yes** ☒ **No**

Part Two IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTION IN PART TWO, THAT PERSON IS ELIGIBLE ONLY FOR THE GRADED BENEFIT PRODUCT.	
5. 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 before age 50 or diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)?	☐ Yes ☒ No
(b) Hepatitis C?	☐ Yes ☒ No
(c) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?	☐ Yes ☒ No
6. In the past 4 years, 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:	
(a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)?	☐ Yes ☒ No
(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?	☐ Yes ☒ No
(c) Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis?	☐ Yes ☒ No
7. In the past 2 years, 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:	
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement?	☐ Yes ☒ No
(b) Stroke or Transient Ischemic Attack (TIA)?	☐ Yes ☒ No
8. In the past 2 years, has the Proposed Insured:	
(a) been convicted of or currently awaiting trial for a felony?	☐ Yes ☒ No
(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?	☐ Yes ☒ No
(c) used unlawful drugs in any form or abused or misused prescription drugs?	☐ Yes ☒ No
9. In the past 2 years, has the Proposed Insured been hospitalized by a physician or health care provider for any mental or nervous disorder?	☐ Yes ☒ No
10. In the past 12 months, has the Proposed Insured consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding?	☐ Yes ☒ No

NOTE: If the Proposed Insured answers all above questions "No", that person is eligible for the Level Benefit Product.

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

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

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PLAN INFORMATION

Plan:
☒ Level Benefit Product ☐ Graded Benefit Product
Amount Applied For $ 40,000

Rider: (Only if selecting Level Benefit Product)
☒ Accidental Death Rider

Payment Mode:
☐ Annual ☐ Semiannual ☐ Quarterly ☒ Monthly (Automated Bank Account Withdrawal)
Modal Premium $ 135.21 Collected Premium $ draft

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

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

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?
State Farm	John D Doe	100,000	☐ Yes ☒ No
			☐ Yes ☐ No

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: To the best of my knowledge and belief, 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.

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If applying for the Graded Benefit Product: I understand that a reduced death benefit amount is payable during the first two policy years if death results from sickness or other natural causes. The full face amount is payable during the first two policy years if death results from an accident.

Signed at: Englewood (City) OH (State)

John D Doe
Signature of Proposed Insured

Date: 11-4-2015

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

Date:

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.

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

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

In the past 13 months, has the Proposed Insured informed you, the Producer(s), that he/she has any:

pending or existing life insurance or annuity contracts with the company or any other company? ☒ Yes ☐ No

life insurance coverage with the company or any other company that has lapsed or was cancelled? ☐ Yes ☒ No

(If the above questions are 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? 1 day

How long have you known the Proposed Owner? 1 day

Previous residence of Proposed Insured for the past five years.

Street Address	City	State	Zip Code

I/We conducted said interview in person ☒ Yes ☐ No

If "No," please explain

Signature of Producer #1	Producer E-mail	Production Number	Date
Cody Mo Beck	Cbeck@equisfinancial.com	0555555	11-4-2015
Signature of Producer #2	Producer E-mail	Production Number	Date
Cody M. Beck			
Print Producer #1 Name	Print Producer #2 Name	Agency Name	

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List any additional information or comments below:

L8532_0515

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 $ 135.21
   - [X] 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 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
- [ ] Business owned by Proposed Insured/Insured or spouse
- [ ] Power of Attorney or legal guardian
- [ ] Living Trust
- [ ] Other _____

ACCOUNT INFORMATION

1. John Doe 56-7940/2422 1016
2. _____
3. DATE _____

PAY TO THE ORDER OF _____ $ _____ DOLLARS

VOID

Wright-Patt CREDIT UNION, INC.
Fairborn, Ohio 45324-6219
Save Better. Borrow Smarter. Learn A Lot!

MEMO _____

⑆241227940⑆190000 ⑈1016

Card numbers)

AUTH

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 (Mo./Day/Yr.) X John D Doe (Authorized Signature as Shown on Account)

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) $40,000 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 $40,000.

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 $ 135.21

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 Mc Beck — Signature of Producer — Date: 11-4-2015

Signature of Producer — Date

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

Mutual of Omaha

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefit received under the rider may be taxable. Receipt of the accelerated death 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 the benefit.

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness or Nursing Home Confinement 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 or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

While the rider is in force and the insured has a terminal illness or is under nursing home confinement, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. Nursing home confinement means that the insured has been confined to a nursing home for at least 90 consecutive days and is expected to remain confined for the remainder of his or her life. A physician must certify that the insured has a terminal illness or is under nursing home confinement.

The amount available for the accelerated death benefit is your policy's death benefit. You may receive the accelerated death benefit only once.

For a terminal illness, we will reduce the accelerated death benefit by 6%.

For nursing home confinement, we will reduce the accelerated death benefit by the nursing home confinement factor. The nursing home confinement factor varies by policy year as shown in the rider. We will also reduce the accelerated death benefit by a $100 charge and by the amount of any loans and unpaid premiums.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The rider will terminate when the accelerated death benefit is paid.

NOTE: If the policy is issued as a graded death benefit, the accelerated death benefit is not available.

Acknowledgment

I acknowledge receipt of this disclosure form.

John D Doe
Applicant/Owner Signature

11-4-2015
Date

I have provided this disclosure form to the applicant/owner.

Cody M. Beck
Producer Signature

11-4-2015
Date

Company's Copy

L8517

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 D Doe	Printed Name of Proposed Applicant/Owner
Signature of Proposed Applicant/Owner: John D 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.)