MUTUAL of OMAHA

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

INDIVIDUAL LIFE INSURANCE APPLICATION

PROPOSED INSURED

First Name	MI	Last Name	Suffix	☐ Male ☐ Female	Height	Weight	Social Security No.

Home Address Street	Apt/Ste#	City	State	Zip	State of Birth	Date of Birth

Phone No.	E-mail	Driver's License No.	Driver's License State

Are you a U.S. citizen or legal permanent 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 tobacco or any product containing nicotine ?..... ☐ **Yes** ☐ **No**

OWNER (Complete only if Owner/Applicant is different from Proposed Insured)

First Name	MI	Last Name	Suffix	Relationship to Proposed Insured

Street Address	Apt/Ste#	City	State	Zip	Phone No.	Social Security No.

☐ Male ☐ Female	Date of Birth	E-mail	Citizenship Country

UNDERWRITING

Part One IF THE PROPOSED INSURED ANSWERS "YES" TO QUESTIONS 2-5 IN PART ONE, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.

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. 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 by a member of the medical profession 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, advised by a member of the medical profession to use oxygen equipment to assist breathing (excluding use for sleep apnea) or defibrillator?	☐ **Yes** ☐ **No**
3. Has the Proposed Insured **ever** (i) been diagnosed with, (ii) received treatment for, or (iii) been advised by a member of the medical profession to seek treatment for:	
(a) Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Hydrocephalus, Muscular Dystrophy, Quadriplegia, Paraplegia, Down Syndrome, Intellectual Developmental Disorder, Congestive Heart Failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type?	☐ **Yes** ☐ **No**
(b) insulin shock, diabetic coma, amputation due to diabetic complications, End Stage Renal Disease or requiring dialysis?	☐ **Yes** ☐ **No**
(c) an organ or bone marrow transplant?	☐ **Yes** ☐ **No**
(d) a terminal medical condition that is expected to result in death within the next twelve (12) months?	☐ **Yes** ☐ **No**
4. In the past 12 months, has the Proposed Insured been:	
(a) 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, hospitalization, or other procedure which has not been done or for which results are not known?	☐ **Yes** ☐ **No**
(b) diagnosed by a member of the medical profession as having heart disease or heart surgery of any kind?	☐ **Yes** ☐ **No**
5. In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for any form of cancer (except basal or squamous cell skin cancer)?	☐ **Yes** ☐ **No**

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UNDERWRITING, Continued

Part Two **IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTION IN PART TWO, THAT PERSON IS ELIGIBLE ONLY FOR THE GRADED BENEFIT PRODUCT.**

6. Has the Proposed Insured **ever** (i) been diagnosed with, (ii) received treatment for, or (iii) been advised by a member of the medical profession to seek treatment for:	
(a) Diabetes before age 45?	☐ Yes ☐ No
(b) Diabetes at any age with complications or history of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve), Peripheral Vascular Disease (PVD or PAD), Coronary Artery Disease (CAD) or Stroke?	☐ Yes ☐ No
(c) Hepatitis C?	☐ Yes ☐ No
(d) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?	☐ Yes ☐ No
7. In the past 4 years, has the Proposed Insured: (i) been diagnosed with, (ii) received treatment for, or (iii) been advised by a member of the medical profession to seek treatment for:	
(a) Cancer, Leukemia, or any other internal cancer or Melanoma (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
8. In the past 2 years, has the Proposed Insured: (i) been diagnosed with, (ii) received treatment for, or (iii) been advised by a member of the medical profession to seek treatment for:	
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, Pacemaker or Valvular Heart Disease with surgical repair or replacement?	☐ Yes ☐ No
(b) Stroke or Transient Ischemic Attack (TIA)?	☐ Yes ☐ No
9. 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 by a member of the medical profession to have treatment for alcohol or drug abuse, convicted of driving under the influence of drugs or alcohol or convicted more than once of reckless driving?	☐ Yes ☐ No
(c) used unlawful drugs in any form (other than marijuana) or abused or misused prescription drugs?	☐ Yes ☐ No
10. In the past 2 years, has the Proposed Insured been hospitalized by a member of the medical profession for any mental or nervous disorder?	☐ Yes ☐ No
11. In the past 12 months, has the Proposed Insured been diagnosed or treated by a member of the medical profession 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)

PLAN INFORMATION

Plan:
☐ Level Benefit Product ☐ Graded Benefit Product
Amount Applied For $ _____

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

PREMIUM INFORMATION

Premium Method	☐ Direct Bill ☐ Bank Draft *(Complete Payment Authorization Form)* ☐ Other(Please Explain)_____
Frequency of Modal Premium	☐ Monthly (*Bank Draft Only*) ☐ Annual ☐ Semi-Annual ☐ Quarterly

Modal Premium $_____ Collected Premium $_____

Name & Address of Payor (if other than Proposed Insured/Owner)_____

Relationship of Payor (if other than Proposed Insured/Owner)_____

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

Primary Beneficiary First Name	MI	Last Name	Suffix	Relationship to Insured	Date of Birth
Contingent Beneficiary First Name	**MI**	**Last Name**	**Suffix**	**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?
			☐ **Yes** ☐ **No**
			☐ **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, LLC (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 information regarding communicable or infectious conditions or 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. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. 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 United of Omaha. 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 to the best of my knowledge and belief. 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.

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:_____
City State

_____ Date: _____
Signature of Proposed Insured

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

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