

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



KANSAS – 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:

- Accelerated Death Benefit Rider
- Accidental Death Benefit Rider (OPTIONAL)

GRADED BENEFIT PRODUCT (IF AVAILABLE):

- 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
- Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor - Complete this form if applicable. The client must sign and retain a copy for their records.

Supplemental 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.



LAP1162_KS_0613

01/04/2016

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL OF OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



Application for Individual Life Insurance

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	Driver's License No.		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					
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?					<input type="checkbox"/> Yes <input type="checkbox"/> 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?					<input type="checkbox"/> Yes <input type="checkbox"/> 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)?					<input type="checkbox"/> Yes <input type="checkbox"/> 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 health care provider?					<input type="checkbox"/> Yes <input type="checkbox"/> 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?					<input type="checkbox"/> Yes <input type="checkbox"/> 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?					<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) advised to receive or have received an organ or bone marrow transplant?					<input type="checkbox"/> Yes <input type="checkbox"/> 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 12 months?					<input type="checkbox"/> Yes <input type="checkbox"/> 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?					<input type="checkbox"/> Yes <input type="checkbox"/> No
(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
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)?					<input type="checkbox"/> Yes <input type="checkbox"/> No

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

<p>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:</p> <p>(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)?</p> <p>(b) Hepatitis C?</p> <p>(c) 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>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:</p> <p>(a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)? ...</p> <p>(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?</p> <p>(c) 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>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:</p> <p>(a) 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) 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>8. In the past 2 years, has the Proposed Insured:</p> <p>(a) been convicted of or currently awaiting trial for a felony?</p> <p>(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>(c) 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>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?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. In the past 12 months, 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>

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: <input type="checkbox"/> Level Benefit Product <input type="checkbox"/> Graded Benefit Product Amount Applied For \$ _____	Rider: (Only if selecting Level Benefit Product) <input type="checkbox"/> Accidental Death Rider
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Payment Mode:
 Annual Semiannual Quarterly Monthly (Automated Bank Account Withdrawal)
 Modal Premium \$ _____ Collected Premium \$ _____

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

Primary Beneficiary	Relationship to Insured	Date of Birth
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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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 12 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. As long as the applicant is eligible for the exact policy applied for according to United of Omaha's underwriting standards then in effect, coverage will be in force when this application and the initial premium payment are received by United of Omaha Life Insurance Company, unless and until the applicant is notified in writing of their ineligibility and premiums have been refunded. If no premium is received with the application, 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.

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- CONTINUED ON NEXT PAGE -



Fraud Warning: 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 as determined by a court of 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

Signature of Proposed Insured

Date: _____

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.

1. 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
2. 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
3. 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

(If the above questions are answered "Yes," fulfill all state and company requirements.)

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

If "Yes," state relationship _____

5. How long have you known the Proposed Insured? _____

6. How long have you known the Proposed Owner? _____

7. Previous residence of Proposed Insured for the past five years.

Street Address	City	State	Zip Code

8. I/We conducted said interview in person Yes No

If "No," please explain _____

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

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Producer Report

1 Was a Personal Health Interview (PHI) conducted by Apptical Corporation as a part of the application process?..... Yes No

If Yes, please provide the PHI number_____

2 List any additional information or comments below:

L8532_0615



UNITED OF OMAHA LIFE INSURANCE COMPANY

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



PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: _____ 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 \$ _____

- 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: _____ Social Security No. _____

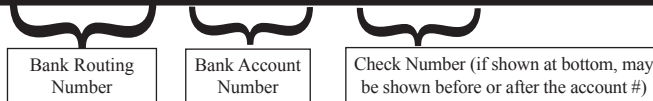
If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation required)

- Employer
- Business owned by Proposed Insured/Insured or spouse
- Power of Attorney or legal guardian
- Living Trust
- Other _____

ACCOUNT INFORMATION

1. Account Type (check one): Checking Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check here.
Bank Routing Number: _____ Bank Account Number: _____
(Do not use Debit/Credit Card numbers)

Memo _____	Signed By: _____	
1:123456789:1	12345678 11*	1234 11*



AUTHORIZATION

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 _____ X _____
Mo./Day/Yr. 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: _____

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.
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CONDITIONS	<p>Conditions under which a benefit may be payable under this Receipt prior to policy delivery:</p> <ol style="list-style-type: none"> 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. <p>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.</p>
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END DATE	<p>This Receipt and any coverage provided hereunder will END on the earliest of the following dates:</p> <ol style="list-style-type: none"> 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.
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SIGNATURES	<p>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.</p> <p>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.</p> <p>Signature of Proposed Insured _____ Date _____</p> <p>Signature of Other Proposed Insured _____ Date _____</p> <p>Signature of Applicant/Owner (if other than Proposed Insured) _____ Date _____</p> <p>Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> Amount remitted/authorized \$ _____</p> <p>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.</p> <p>Signature of Producer _____ Date _____</p> <p>Signature of Producer _____ Date _____</p> <div style="text-align: center;">  </div>
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UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



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.

Applicant/Owner Signature

Date

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

Producer Signature

Date



AUTHORIZATION FOR RELEASE OF INFORMATION TO MY INSURANCE AGENT, AGENCY AND/OR AUTHORIZED THIRD PARTY VENDOR

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.



I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

 X _____ Signature of Applicant A	_____ Date	 X _____ Signature of Applicant B	_____ Date
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IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s).



CONDITIONAL RECEIPT (“RECEIPT”)

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

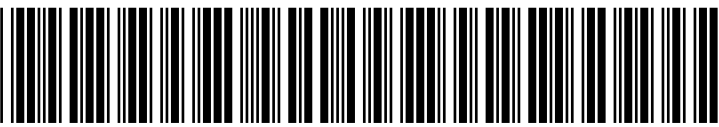
IF ANY PROPOSED INSURED DIES WHILE COVERAGE UNDER THIS RECEIPT IS IN EFFECT, WE WILL PAY TO THE BENEFICIARY(IES) NAMED IN THE APPLICATION THE AMOUNT DESCRIBED IN THE SECTION BELOW ENTITLED “BENEFIT”.

DATE OF RECEIPT: _____

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.
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CONDITIONS	<p>Conditions under which a benefit may be payable under this Receipt prior to policy delivery:</p> <ol style="list-style-type: none"> 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. <p>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.</p>
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END DATE	<p>This Receipt and any coverage provided hereunder will END on the earliest of the following dates:</p> <ol style="list-style-type: none"> 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.
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SIGNATURES	<p>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.</p> <p>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.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Signature of Proposed Insured _____</td> <td style="width: 50%; border: none;">Date _____</td> </tr> <tr> <td style="border: none;">Signature of Other Proposed Insured _____</td> <td style="border: none;">Date _____</td> </tr> <tr> <td style="border: none;">Signature of Applicant/Owner (if other than Proposed Insured) _____</td> <td style="border: none;">Date _____</td> </tr> </table> <p>Payment Method: Check <input type="checkbox"/> Electronic Transaction Authorization <input type="checkbox"/> Amount remitted/authorized \$ _____</p> <p>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.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Signature of Producer _____</td> <td style="width: 50%; border: none;">Date _____</td> </tr> <tr> <td style="border: none;">Signature of Producer _____</td> <td style="border: none;">Date _____</td> </tr> </table> <div style="text-align: center; margin-top: 10px;">  </div>	Signature of Proposed Insured _____	Date _____	Signature of Other Proposed Insured _____	Date _____	Signature of Applicant/Owner (if other than Proposed Insured) _____	Date _____	Signature of Producer _____	Date _____	Signature of Producer _____	Date _____
Signature of Proposed Insured _____	Date _____										
Signature of Other Proposed Insured _____	Date _____										
Signature of Applicant/Owner (if other than Proposed Insured) _____	Date _____										
Signature of Producer _____	Date _____										
Signature of Producer _____	Date _____										

United of Omaha Life Insurance Company – Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports, where applicable. You also have the right to seek correction of personal information you believe to be inaccurate. In the event of an adverse underwriting decision, our Company will provide in writing the specific reason for the underwriting decision.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

L8303

MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. United of Omaha Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. upon request, will supply such company with the information in its file.

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

United of Omaha Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

L7941



UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



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.

Applicant/Owner Signature

Date

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

Producer Signature

Date



AUTHORIZATION FOR RELEASE OF INFORMATION TO MY INSURANCE AGENT, AGENCY AND/OR AUTHORIZED THIRD PARTY VENDOR

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.



I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

 X _____ Signature of Applicant A	_____ Date	 X _____ Signature of Applicant B	_____ Date
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UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Important Notice Regarding Replacement of Life and Annuity Insurance

(To be used where the existing and proposed policies are written by different companies.)

Our agent is recommending that you purchase a life insurance policy or annuity contract from United of Omaha. In connection with this purchase, you have indicated, either as a result of our agent's recommendation or at your own initiative, that you may terminate or change your existing policy issued by another insurance company or that you may obtain a loan from that company against your policy to pay premiums on the proposed policy. Any of these actions is a replacement of life or annuity insurance. This notice must be given to you. Please read this notice carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before your decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and of your existing insurance coverage.

To this end, we are required to give you a Policy Summary including complete information on the proposed policy no later than when that policy is delivered to you. In addition, we are required to notify the insurance company that issued your existing policy. That company may then furnish you additional information concerning your existing policy. You may want to contact that company or its agent for additional information and advice or discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misstatement or omission on your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values may grow slower initially because the Company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have received your application and notified the other insurance company (which we are required to do by state regulation at the time we issue your policy), you will have 20 days from the date the proposed policy is delivered to you to cancel the policy issued on your application and receive back all payments you made to us.

CAUTION

If, after studying the information made available to you, you do decide to replace the existing life or annuity insurance with our life insurance policy or annuity contract, you are urged not to take action to terminate or alter your existing life or annuity insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life or annuity insurance for which you have applied, you may find yourself unable to purchase other life or annuity insurance or able to purchase it only at substantially higher rates.

If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months? . . . YES NO

I have received and read a copy of this Replacement Notice.

Applicant's/Owner's Signature

Date



UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Important Notice Regarding Replacement of Life and Annuity Insurance

(To be used where the existing and proposed policies are written by different companies.)

Our agent is recommending that you purchase a life insurance policy or annuity contract from United of Omaha. In connection with this purchase, you have indicated, either as a result of our agent's recommendation or at your own initiative, that you may terminate or change your existing policy issued by another insurance company or that you may obtain a loan from that company against your policy to pay premiums on the proposed policy. Any of these actions is a replacement of life or annuity insurance. This notice must be given to you. Please read this notice carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before your decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and of your existing insurance coverage.

To this end, we are required to give you a Policy Summary including complete information on the proposed policy no later than when that policy is delivered to you. In addition, we are required to notify the insurance company that issued your existing policy. That company may then furnish you additional information concerning your existing policy. You may want to contact that company or its agent for additional information and advice or discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misstatement or omission on your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values may grow slower initially because the Company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

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CAUTION

If, after studying the information made available to you, you do decide to replace the existing life or annuity insurance with our life insurance policy or annuity contract, you are urged not to take action to terminate or alter your existing life or annuity insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life or annuity insurance for which you have applied, you may find yourself unable to purchase other life or annuity insurance or able to purchase it only at substantially higher rates.

If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months? . . . YES NO

I have received and read a copy of this Replacement Notice.

Applicant's/Owner's Signature

Date





LIFE APPLICATION SUBMISSION FORM

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

Comments: _____

Name of Insured

Name of Agent	Production Number	Phone Number	Email Address

Next Highest Upline	Production Number	Phone Number	Email Address

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

