



INDIVIDUAL LIFE INSURANCE APPLICATION

PROPOSED INSURED									
First Name	MI	Last Name	Suffix	<input type="checkbox"/> Male	Height	Weight	Social Security No.		
				<input type="checkbox"/> Female					
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? <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 tobacco or any product containing nicotine? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	
<input type="checkbox"/> Male <input type="checkbox"/> 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)?								<input type="checkbox"/> Yes <input type="checkbox"/> 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?								<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, advised by a member of the medical profession to use oxygen equipment to assist breathing (excluding use for sleep apnea) or defibrillator?								<input type="checkbox"/> Yes <input type="checkbox"/> 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?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) insulin shock, diabetic coma, amputation due to diabetic complications, End Stage Renal Disease or requiring dialysis?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) an organ or bone marrow transplant?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
(d) a terminal medical condition that is expected to result in death within the next twelve (12) months?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
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?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) diagnosed by a member of the medical profession as having heart disease or heart surgery of any kind?								<input type="checkbox"/> Yes <input type="checkbox"/> 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)?								<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<p>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:</p> <p>(a) Diabetes before age 45?</p> <p>(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? ...</p> <p>(c) Hepatitis C?</p> <p>(d) 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><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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:</p> <p>(a) Cancer, Leukemia, or any other internal cancer or Melanoma (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>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:</p> <p>(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?</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>9. 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 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?</p> <p>(c) used unlawful drugs in any form (other than marijuana) 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>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?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>11. In the past 12 months, has the Proposed Insured been diagnosed or treated by a member of the medical profession 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)

PLAN INFORMATION

<p>Plan:</p> <p><input type="checkbox"/> Level Benefit Product <input type="checkbox"/> Graded Benefit Product</p> <p>Amount Applied For \$ _____</p>	<p>Rider: (Only if selecting Level Benefit Product)</p> <p><input type="checkbox"/> Accidental Death Rider</p>	
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PREMIUM INFORMATION

Premium Method	<input type="checkbox"/> Direct Bill <input type="checkbox"/> Bank Draft (<i>Complete Payment Authorization Form</i>) <input type="checkbox"/> Other(Please Explain) _____
Frequency of Modal Premium	<input type="checkbox"/> Monthly (<i>Bank Draft Only</i>) <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> 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

- Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company? Yes No
- 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
			<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, 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



Signature of Proposed Insured

Date: _____

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

Date: _____

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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 for withdrawal for a premium payment.

PAYMENT INFORMATION FOR THE FIRST PAYMENT- CAN BE DIFFERENT THAN THE ONGOING PAYMENTS

Initial Premium Payment (select only one option) Amount Quoted \$ _____

- Deduct premium immediately upon approval/issue
- Deduct initial premium on or after: _____/_____/_____ (Please Note: If the policy issue is after the date selected, the initial payment will be deducted on the date the policy is issued or all delivery requirements are received.)
- Check collected and mailed to Mutual of Omaha

Money will be deducted from your account as stated above. The first deduction may occur on a date different than the ongoing payments. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first deduction may exceed one regular payment amount. We **CANNOT** establish electronic payments from foreign banks.

PAYMENT INFORMATION FOR ONGOING PAYMENTS- AUTOMATIC BANK ACCOUNT DEDUCTION

Ongoing Automatic Monthly Premium Payments (Once a Month)- Select only one option

- Choose the day payments will be deducted every month from your bank account:
(1st through the 28th or Last Day of every month) _____
-OR-
- Choose the week and weekday that payments will be deducted every month from your bank account:
(For example, 3rd Wednesday of every month)

Week (1st, 2nd, 3rd, 4th, Last) _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date lands on a weekend or holiday, the payment will process on the following business day.**

PAYOR INFORMATION

Name of payor as shown on bank account: _____

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 may be required)

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

PAYOR ACCOUNT INFORMATION

1. Account Type (check one): Checking Savings

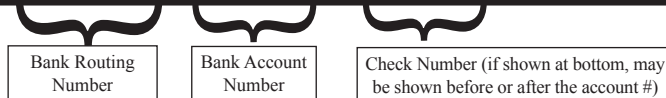
2. Name of Financial Institution: _____

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 *
1234	*



PAYOR AUTHORIZATION

I authorize United of Omaha Life Insurance Company to initiate any initial or recurring preauthorized electronic transfers from my account. I understand the amounts may vary as premium shortages may result from a variety of reasons, including underwriting adjustments. 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 Life Insurance Company may require written confirmation within 15 days after my verbal notice.

Date _____ X _____
Mo./Day/Yr. Payor Authorized Signature as Shown on Account

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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