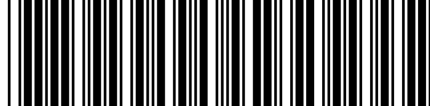
UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

APPLICATION for

CHILDREN'S WHOLE LIFE INSURANCE

CALIFORNIA



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United of Omaha Life Insurance Company
A Mutual *of* Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

✍ *Checklist for Submitting a Completed 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

☐ **Application**

1. Answer all questions completely.
2. Leave all applicable forms with the proposed insured.
3. Sign and Date in all places indicated.

☐ **Complete Premium Collection Section**

A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected.

☐ **Financial Institution Consumer Disclosure**

If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

☐ **Any Additional Information or Comments**

Include any supplemental information about your client

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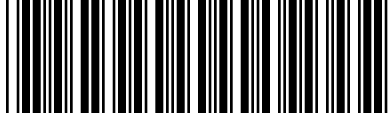
NOTE: Replacement forms can be downloaded from Sales Professional Access (SPA) at www.mutualofomaha.com as needed to accompany the application.

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION



L8555

Children's Whole Life Application

Application for Whole Life Insurance

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

Home Office Use
CWL

Section A Owner/Applicant

1 Owner/Applicant ______________________________
First Name Initial Last Name

2 Social Security Number ______-______-______ Age ______ ☐ Male ☐ Female

3 Birth Date ______________ E-mail Address ______________ Phone Number (____) ______________
Month Day Year

4 Legal Residence Address ______________________________
Street

____
City State ZIP

5 Are you a citizen of the United States? ☐ **Yes** ☐ **No** If "No," do you have an Alien Registration Receipt Card (also known as a "Permanent Residency Card" or "Green Card")? ☐ **Yes** ☐ **No** If "Yes," Card Number ______________
Date of arrival in the United States ______________

6 **Beneficiary:** You will be the Beneficiary unless you name someone else below.

Please Print______________________________
First Name Initial Last Name Relationship to Proposed Insured

Section B Proposed Insured(s) Information

	First Name	Middle Initial	Last Name	Age	Date of Birth	Sex M/F	Coverage Amount	Premium
1								$
2								$
3								$
4								$
							Total premium enclosed	$

Are all Proposed Insureds citizens of the United States? ☐ **Yes** ☐ **No** If "No," do all Proposed Insureds have an Alien Registration Receipt Card (also known as a "Permanent Residency Card" or "Green Card")? ☐ **Yes** ☐ **No** If "Yes," Card Number(s) ______________ Date(s) of arrival in the United States ______________

Section C Other Coverage and Replacement Information

1 List below all life insurance policies and/or annuity contracts on any of the Proposed Insureds that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) If none, check the following box: ☐ **None**

2 Have any of the Proposed Insureds had, or do they intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? ☐ **Yes** ☐ **No** If "Yes," check the appropriate box(es) below. The Producer shall comply with any additional state and/or Company replacement requirements.

Company	Proposed Insured	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced?	Assigned or Sold?
				☐**Yes** ☐**No**		☐**Yes** ☐**No**	☐**Yes** ☐**No**	☐**Yes** ☐**No**
				☐**Yes** ☐**No**		☐**Yes** ☐**No**	☐**Yes** ☐**No**	☐**Yes** ☐**No**

3 If this is a replacement, have you received a copy of the Notice of Replacement (if required in your state)? ☐ **Yes** ☐ **No**

Section D Health Information

Have any of the Proposed Insureds received medical care for or had:

(a) a heart or circulatory system disease, birth defect, or mental or developmental disorder including autism and Down's Syndrome? ☐ **Yes** ☐ **No**

(b) any other chronic medical condition which has required care within the past 3 years? ☐ **Yes** ☐ **No**

NOTE: Provide details for "Yes" answers. Please include Proposed Insured's name and illness or condition. (Use additional sheet if necessary.)

____

____

Section E Premium and Billing Information

1 Amount collected $ _______________ Modal Premium for Proposed Insured(s) $ _______________

2 Mode of Payment ☐ Monthly Bank Service Plan ☐ Annual ☐ Semiannual ☐ Quarterly

AUTHORIZATION TO WITHDRAW FUNDS BY UNITED OF OMAHA LIFE INSURANCE COMPANY (United of Omaha)

(If Mode of Payment is Monthly Bank Service Plan (BSP) – select one below)

☐ Monthly Bank Service Plan **(initial premium collected with the application)** — I/We have paid the initial premium by check to United of Omaha.

☐ Monthly Bank Service Plan **(initial premium paid by electronic funds transfer)**— I/We authorize the initial premium for the policy(ies) to be paid to United of Omaha, by electronic funds transfer, from the bank account identified below. The withdrawal for the initial premium payment will occur only if and when the application(s) is/are approved for issue by United of Omaha.

If Monthly Bank Service Plan, complete information below OR attach a voided check:

Routing Number and Transit Number (9-digit number) _______________

Account Number _______________

Name as shown on account _______________
First Initial Last

Social Security Number of Payor _______ – _______ – _______

Specify the date renewal premiums will be withdrawn (1st through the 28th of each month) _______

Section F Agreement

I am the parent, grandparent or guardian of the Proposed Insured(s) and I represent that my above answers are true and complete to the best of my knowledge and belief. I also understand that this coverage will not be in force until this application is completed in full and approved by United of Omaha Life Insurance Company, and the initial premium is received during the lifetime of the Proposed Insured(s).

I have read and understand this Agreement Section and I approve all the answers as recorded in this application.

Signed at: _______________ Date _______________
City State Month Day Year

____
Signature of Owner/Applicant Relationship to Proposed Insured(s)

By signing below, I/We authorize renewal premiums to be automatically paid to United of Omaha, by electronic funds transfer, from the bank account identified and on the date specified on the Bank Service Plan (BSP) authorization form. I/We understand and agree that these authorized withdrawals from the bank account for premium payments will continue until this authorization is cancelled in writing.

____
Authorized Signature as shown on bank account if payment mode is Bank Service Plan (BSP) Date Month Day Year

In addition to the above Agreement, has the Applicant informed you, the Producer(s), that any Proposed Insured has one or more existing life insurance policies and/or annuity contracts in force? ☐ **Yes** ☐ **No**

Do you, the Producer(s), have reason to believe that the policy applied for has replaced or will replace any existing life insurance policy(ies) and/or annuity contract(s)? ☐ **Yes** ☐ **No**

If "Yes," the Producer(s) shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.

Have you, the Producer(s), asked each question exactly as written and recorded the answer completely and accurately? ☐ **Yes** ☐ **No**

(If "No," explain.) _______________

Did you, the Producer(s), give the Applicant the Life Insurance Buyer's Guide? ☐ **Yes** ☐ **No**

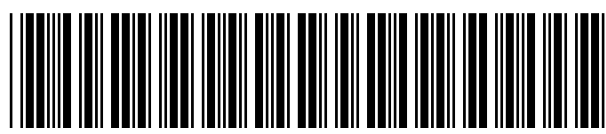
(If "No," explain.) _______________

____
Signature of Producer #1 Production Number Date Month Day Year

____
Signature of Producer #2 Production Number Date Month Day Year

____
Print or Stamp Producer #1 Name Print or Stamp Producer #2 Name Agency Name

Steve Shorr Insurance 310.519.1335 www.HealthReformQuotes.com



UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

Third Party Notice Request Form

You have the right to designate a person, in addition to yourself, to receive notice that your premium is past due and has not been paid. This notice will be sent at least 30 days prior to the effective date of cancellation of your policy or certificate. This notice will state the amount of premium, the date by when the premium must be paid to avoid policy cancellation and the date on which coverage terminates.

You can designate this additional person to receive notice of nonpayment now or at a later time, provided the policy is in force, and you give us written notice containing the additional person's name, address and phone number.

You have the right to change this third-party designation at any time; however, you must submit the change in writing to the address below.

PLEASE COMPLETE EITHER SECTION 1 OR SECTION 2 AND RETURN TO US.

Section 1

I wish to designate an additional person to receive notice of nonpayment of premium.

Policyowner/Certificateholder: ____

Policy Number: ______________________________ Date: ______________

Third Party: ____

(Please print name of other person to receive notice of nonpayment)

Third Party Address: ____

(Street Address) (City) (State) (ZIP)

Third Party Phone: (______) ____________

(Area Code) (Number)

Signature of Policyowner/Certificateholder

____

Date______________________________

Section 2

I do not wish to designate an additional person to receive notice of nonpayment of premium.

Signature of Policyowner/Certificateholder

____

Date______________________________

Direct all correspondence to: United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

L8524

Notice Regarding Replacement
Replacing Your Life Insurance Policy or Annuity?

Are you thinking about buying a new life insurance policy or an annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in **your** best interest.

We are required by law to notify your existing company that you may be replacing their policy.

_______________________________	____________	_______________________________
Applicant's/Owner's Signature	Date	Agent's Signature

Notice Regarding Replacement
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______________________________	__________	______________________________
Applicant's/Owner's Signature	Date	Agent's Signature