United of Omaha Life Insurance Company
A Mutual *of* Omaha Company

Florida – Application for Life Insurance

Living Promise Product – One Base Policy per Application

✍ ***Checklist for Submitting a Complete Application***

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

☞ Please choose the precise Plan, Rider, and amount of insurance applied for

❑ **Level Benefit Product:**	❑ **Graded Benefit Product (if available):**
• Accelerated Death Benefit Rider • Accidental Death Benefit Rider (optional)	• No Riders Available

Application Submission Guidelines

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

Important Forms

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

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 ☐ Male ☐ 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? ☐ **Yes** ☐ **No**
(If "No", you are not eligible for coverage.)

In the past 12 months, has the Proposed Insured used any form of tobacco or nicotine replacement therapy? ☐ **Yes** ☐ **No**

(Optional)- Secondary Addressee: To help make sure your policy stays in force, you can have the person listed below receive a notice when your policy is past due and has not been paid.
Name _____ Address _____

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 ☐ Male ☐ 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 by a licensed 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, or oxygen equipment to assist breathing (excluding use for sleep apnea)? . . . . . ☐ **Yes** ☐ **No**

2. Has the Proposed Insured **ever been**:
- **(a)** tested positive for exposure to the HIV infection HIV antibodies in a test taken for the purpose of obtaining insurance or been diagnosed by a physician as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?. . . . . ☐ **Yes** ☐ **No**
- **(b)** diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Quadriplegia, Paraplegia, Down's Syndrome, mental incapacity, congestive heart failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type?. . . . . ☐ **Yes** ☐ **No**
- **(c)** diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed by a licensed member of the medical profession with End Stage Renal Disease or requiring dialysis?. . . . . ☐ **Yes** ☐ **No**
- **(d)** advised by a licensed member of the medical profession to receive or have received an organ or bone marrow transplant? . . . . . ☐ **Yes** ☐ **No**
- **(e)** diagnosed by a physician or health care provider as having a terminal medical condition that is expected to result in death within the next 12 months?. . . . . ☐ **Yes** ☐ **No**

3. In the past 12 months, has the Proposed Insured been:
- **(a)** advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known? . . . . . ☐ **Yes** ☐ **No**
- **(b)** diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind?. . . ☐ **Yes** ☐ **No**

4. In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for any form of cancer (except basal or squamous cell skin cancer)? . . . . . ☐ **Yes** ☐ **No**

T087LFL14A

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

5. Has the Proposed Insured **ever** (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Diabetes before age 50 or diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)?	☐ **Yes** ☐ **No**
(b) Hepatitis C?	☐ **Yes** ☐ **No**
(c) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?	☐ **Yes** ☐ **No**
6. **In the past 4 years**, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)?	☐ **Yes** ☐ **No**
(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?	☐ **Yes** ☐ **No**
(c) Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis?	☐ **Yes** ☐ **No**
7. **In the past 2 years**, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement?	☐ **Yes** ☐ **No**
(b) Stroke or Transient Ischemic Attack (TIA)?	☐ **Yes** ☐ **No**
8. **In the past 2 years**, has the Proposed Insured:	
(a) been convicted of, incarcerated for or currently awaiting trial for a felony?	☐ **Yes** ☐ **No**
(b) been treated for or advised by a licensed member of the medical profession to have treatment for alcohol or drug abuse or convicted more than once of reckless driving or driving under the influence of drugs or alcohol?	☐ **Yes** ☐ **No**
(c) used unlawful drugs in any form or abused or misused prescription drugs?	☐ **Yes** ☐ **No**
9. **In the past 2 years**, has the Proposed Insured been hospitalized by a physician or health care provider for any mental or nervous disorder?	☐ **Yes** ☐ **No**
10. **In the past 12 months,** has the Proposed Insured consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding?	☐ **Yes** ☐ **No**

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

OPTIONAL COMMENTS (Not Required) - Provide any additional information available. Exclude any information regarding treatment for HIV/AIDS/ARC.

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

T087LFL14A

PLAN INFORMATION

Plan:	Rider: (Only if selecting Level Benefit Product)
☐ Level Benefit Product ☐ Graded Benefit Product Amount Applied For $ _____	☐ Accidental Death Rider

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?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

AUTHORIZATION and AGREEMENT

Authorization: I authorize any medical provider, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical care facility, MIB, Inc. (MIB), state department of motor vehicles and other entities processing motor vehicle records, insurance companies or consumer reporting agencies to release information about me or my health, such as, medical history, including the presence of HIV infection, AIDS or ARC, mental or physical condition, prescription drug records, drug or alcohol use, driving record or insurance claims information, to""United of Omaha Life Insurance Company ("United of Omaha"). The information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise. I also authorize United of Omaha to disclose information to MIB. I understand that my information received by MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations. This authorization is valid for 24 months from the date signed. I may refuse to sign this authorization but if I refuse, the insurance I am applying for will not be issued. I may revoke this authorization at any time by written notice to the address below. This revocation is limited to the extent that United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha to contest the issuance of the policy or a claim under the policy. I will receive a copy of this authorization.

Agreement: To the best of my knowledge and belief, I represent the information above is true and complete. Any incorrect or misleading answers may void this application and any issued policy effective the issue date. Unless otherwise provided under a conditional receipt, I understand that no insurance shall take effect until all outstanding application requirements have been received, a policy is issued and the first premium is received by United of Omaha during the Proposed Insured's lifetime. The issue date of the policy will be the date shown on the policy, even though coverage may not become effective until a later date. You must immediately notify United of Omaha if there has been a change in the Proposed Insured's health or habits that will change any statement or answer to any question in the application as of the date the policy is delivered. No policy of any kind will be in effect if the Proposed Insured dies or is otherwise ineligible for the insurance for which they applied. No producer can waive or change any receipt or policy provision or agree to issue any policy.

T087LFL14A

- CONTINUED ON NEXT PAGE -

Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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)

Agent Statement:

By signing below, I/we, the Agent(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 Agent(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 Agent(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 conducted said interview in person . . . . . ☐ **Yes** ☐ **No**

If "No," please explain _____

_____ _____ _____ _____
Signature of Agent #1 Agent E-mail Production Number Date

_____ _____ _____ _____
Signature of Agent #2 Agent E-mail Production Number Date

_____ _____
Florida License ID Number, Agent #1 Florida License ID Number, Agent #2

_____ _____ _____
Print Agent #1 Name Print Agent #2 Name Agency Name

T087LFL14A

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:

_____

_____

_____

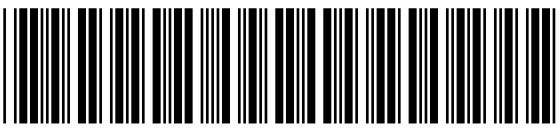
_____

_____

_____

_____

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

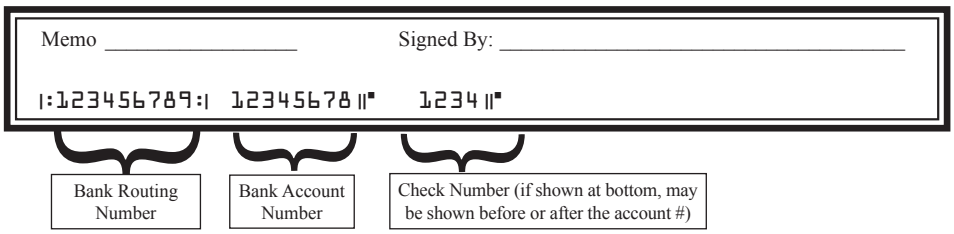
☐ Other _____

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)



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.

Conditions

Conditions under which a benefit may be payable under this Receipt prior to policy delivery:

1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and
2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and
3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and
4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.

If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.

End Date

This Receipt and any coverage provided hereunder will **END** on the earliest of the following dates:

1 60 days from the date of this Receipt; or
2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 The date the Applicant/Owner withdraws the application for insurance.

Signatures

This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.

I/We have read and received a copy of this Receipt and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

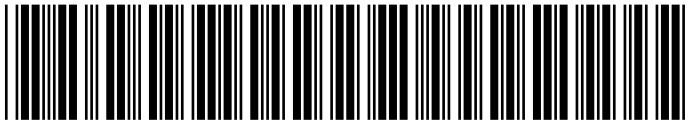
_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized $_____

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.

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date



Third Party Notice

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 extra notice will be sent at least 21 days prior to the effective date of cancellation of your policy or certificate only if you are age 64 or older. This notice will state the amount of premium, the date by when the premium must be paid 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 and address.

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)

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 _____

United *of* Omaha Life Insurance Company Attn: Individual Life Underwriting 9330 State Hwy 133, Blair, 68008

L2401_0604

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 Chronic Illness 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 chronically ill, 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. Chronically ill means that the insured person is unable to perform at least two activities of daily living (ADL's) without substantial assistance from another person. A physician must certify that the insured has a terminal or chronic illness.

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 a chronic illness, we will reduce the accelerated death benefit by the chronic illness confinement factor. The chronic illness 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

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Companion Life Insurance Company

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

M28704

CLIENT FORMS

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.

Conditions

Conditions under which a benefit may be payable under this Receipt prior to policy delivery:

1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and
2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and
3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and
4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.

If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.

End Date

This Receipt and any coverage provided hereunder will **END** on the earliest of the following dates:

1 60 days from the date of this Receipt; or
2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 The date the Applicant/Owner withdraws the application for insurance.

Signatures

This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.

I/We have read and received a copy of this Receipt and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

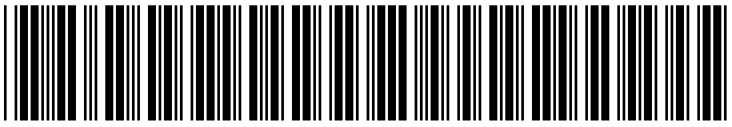
_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized $_____

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.

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date



United of Omaha Life Insurance Company - MIB Group, 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, 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 Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

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

Applicant's/Owner's Copy L7941

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 Chronic Illness 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 chronically ill, 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. Chronically ill means that the insured person is unable to perform at least two activities of daily living (ADL's) without substantial assistance from another person. A physician must certify that the insured has a terminal or chronic illness.

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 a chronic illness, we will reduce the accelerated death benefit by the chronic illness confinement factor. The chronic illness 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

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Companion Life Insurance Company

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

M28704

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Replacement Form

Notice to Applicant Regarding Replacement of Life Insurance or Annuity Contract

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

Yes ☐ No ☐

Do not take action to terminate your existing policy until your new policy has been issued and you have examined it and found it acceptable.

I have read this notice and received a copy of it.

_____ _____

Applicant's/Owner's Signature Date

_____ _____

Agent's Signature Date

_____

Agent's Name (printed or typed)

_____

Agent's Address (printed or typed)

_____

Agent's Company (printed or typed)

Information on policies which may be replaced:

Company Name	Policy Number	Name of Insured

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Replacement Form

Notice to Applicant Regarding Replacement of Life Insurance or Annuity Contract

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

Yes ☐ No ☐

Do not take action to terminate your existing policy until your new policy has been issued and you have examined it and found it acceptable.

I have read this notice and received a copy of it.

_____ _____

Applicant's/Owner's Signature Date

_____ _____

Agent's Signature Date

_____

Agent's Name (printed or typed)

_____

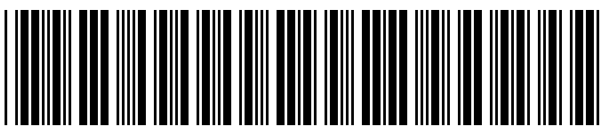
Agent's Address (printed or typed)

_____

Agent's Company (printed or typed)

Information on policies which may be replaced:

Company Name	Policy Number	Name of Insured



Third Party Notice

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 extra notice will be sent at least 21 days prior to the effective date of cancellation of your policy or certificate only if you are age 64 or older. This notice will state the amount of premium, the date by when the premium must be paid 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 and address.

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)

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_____

United *of* Omaha Life Insurance Company Attn: Individual Life Underwriting 9330 State Hwy 133, Blair, 68008