



# FINAL EXPENSE WHOLE LIFE

**Regular Mail:**

United Home Life Insurance Company  
P.O. Box 7192  
Indianapolis, IN 46207-7192

**FAX Number: 317-692-7711****Telephone: 800-428-3001****Overnight Mail:**

United Home Life Insurance Company  
225 South East St  
Indianapolis, IN 46202

\_\_\_\_\_ # pages including cover

**Fax only once.**

Agt Name: \_\_\_\_\_ Agt #: \_\_\_\_\_  
Agt Phone: \_\_\_\_\_ Agt Fax: \_\_\_\_\_  
Agt Email Address: \_\_\_\_\_

How do you prefer to be notified if we should need any underwriting requirements?

E-Mail  Fax  US Mail

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Proposed Insured's Name:** \_\_\_\_\_

Do you personally know the proposed insured?  Yes  No

Have you written insurance on the proposed insured in the past three (3) years?  Yes  No

Did you personally see all persons proposed for insurance and personally view a photo ID (driver's license, passport) of the proposed owner and/or insured?  Yes  No

If No, how was the application taken?

Solicited by:  Mail  Telephone  Internet  Fax  Other \_\_\_\_\_  
(Explain)

Did you identify any unusual behavior or suspicious activity by the proposed owner or insured?  Yes  No

If Yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

**Special Instructions you want us to know:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MAIL POLICY TO:**  **Owner**  **Agent**

**Personal History Interviews (PHIs):**

Do **NOT** complete a PHI if the application being submitted is for the GIWL (Graded Death Benefit Endowment).

**Option 1 (preferred option) Know Before You Go:** You, the agent, initiate a point-of-sale (POS) interview from your client's home by calling **866-333-6557**. Tell the operator this interview is for UHL and the EIWL (graded benefit), Deluxe or Premier plan and hand the phone to your client (**Be specific as to which product you want so that only the plan-specific questions will be asked**). During the call, the interviewer will conduct MIB and Prescription Drug searches to better determine your client's suitability for the product you've selected. Upon completion of the interview, and based on the client's answers to the questions and results of the database searches, the interviewer will tell you whether or not the application should be sent to the Home Office.

**Did you complete a Point of Sale Personal History Interview with your client?  Yes  No**

**Option 2:** UHL will order the PHI after you've completed the application with your client and submitted it to the Home Office. A PHI is required for all EIWL, Deluxe and Premier sales, regardless of face amount. What is the best time to reach this client?

Home Phone (\_\_\_\_) \_\_\_\_\_ available days?  Yes  No

Business Phone (\_\_\_\_) \_\_\_\_\_ available days?  Yes  No

Cell Phone (\_\_\_\_) \_\_\_\_\_ available days?  Yes  No

**If a language other than English is required, please specify \_\_\_\_\_.**

**Important Reminders**

1. Print legibly in English.
2. Keep original app until policy is issued.
3. If faxing, keep fax confirmation message that fax was successful.
4. UHL products use the "age nearest birthday" method for determining the age of the proposed insured for insurance purposes.
5. If the replacement question is answered "Yes," ensure that the applicable replacement form(s) has been completed and included (if required).
6. Cash is not permitted for the payment of premium(s).
7. The Fair Credit Reporting Act/MIB Notice and, if applicable, the Notice of Insurance Information Practices must be given to the proposed insured. These documents must also be provided to any applicant who completes the Know Before You Go (point-of-sale) PHI process, regardless of whether an application is written or not.

# Application for Life Insurance

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

## SECTION 1 – Proposed Insured

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Date of Birth (M-D-Y) \_\_\_\_\_ State of Birth \_\_\_\_\_  Male  
 Female

Marital Status \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Married  Single  Divorced  Separated  Widowed  Civil Union  Domestic Partnership

Social Security Number \_\_\_\_\_ U.S. Citizen:  Yes  No *If no, give immigration status/type of visa:* \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number  
( ) \_\_\_\_\_

Employer/Occupation/Duties/How Long There (Required) \_\_\_\_\_

Billing Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Secondary Addressee (For Past Due Notice) Name \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## SECTION 2 – Ownership (Complete only if Owner is other than Proposed Insured)

Owner Name \_\_\_\_\_ Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_

Owner Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Contingent Owner Name \_\_\_\_\_ Relationship \_\_\_\_\_ Social Security Number \_\_\_\_\_

## SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Contingent Beneficiary Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

## SECTION 4 – Plan of Insurance

Plan of Insurance  Graded Death Benefit Endowment (Guaranteed Issue)  Express Issue Whole Life  
 Express Issue Deluxe  Express Issue Premier  
 Check here if you are willing to accept any product listed in this section for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit in the first 2 or 3 years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.

Face Amount: \$ \_\_\_\_\_

If the Face Amount shown above is \$10,000 or greater and the product issued is the Express Issue Whole Life, the following riders will be attached to the policy: Identity Theft Waiver of Premium Rider, Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

Accidental Death Benefit Rider (not available with Graded Death Benefit Endowment or Express Issue WL) \$ \_\_\_\_\_

## SECTION 5 – Payment Information

Modal Premium:  Annual  Semi-Annual  Qtrly.  PAC\* Modal Premium Amount \$ \_\_\_\_\_  
\$ \_\_\_\_\_ paid with application.

**\*If selected, bank information on Page 5 must be fully completed.**

## SECTION 6 – Other Insurance

Will this insurance replace or change any other insurance policies or annuities?  Yes  No  
If "Yes," please complete any necessary replacement forms.

## SECTION 7 – Nicotine Use

Has the Proposed Insured used nicotine in any form in the past 12 months?  Yes  No

## SECTION 8 – Physician Information

Name and Address of Family Physician (Required) \_\_\_\_\_ Family Physician Telephone Number (Required)  
( ) - \_\_\_\_\_

**SECTION 9 – Medical Questions**

If the plan selected in Section 4 is the Graded Death Benefit Endowment, the Proposed Insured should not answer the health questions below.

**PART A - EXPRESS ISSUE WHOLE LIFE – COMPLETE PART A ONLY**

If any question in Part A is answered "Yes", you are not eligible for Express Issue Whole Life.

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been told that you need an organ transplant or have you been diagnosed as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Do you require assistance to feed, bathe, dress or take your own medication or are you currently confined to a hospital, nursing home, mental facility, hospice, or require home health nursing care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immune disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>D. In the past twelve (12) months:</b>	
1. Other than for temporary or minor conditions, have you been hospitalized two or more times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Other than preventive, maintenance or risk lowering medications prescribed, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), heart attack, stroke, or had heart surgery (including angioplasty)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you used any illegal drugs, been treated for or advised to have treatment for drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART B - EXPRESS ISSUE DELUXE – COMPLETE PARTS A & B ONLY**

If any question in Part B is answered "Yes", you are not eligible for Express Issue Deluxe. Submit the case as Express Issue Whole Life.

<b>A. In the past 2 years:</b>	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer's Disease or Dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Other than preventive, maintenance or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension) or Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Sickle Cell Anemia or Kidney Disease (including dialysis) or Liver Disease (including hepatitis B & C)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. ALS (Lou Gehrig's Disease) or Neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been advised by a medical professional to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you excessively used, been treated for or been advised to have treatment for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>B. In the past 10 years</b> have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**PART C - EXPRESS ISSUE PREMIER – COMPLETE PARTS A, B, & C**

If any question in Part C is answered "Yes", you are not eligible for Express Issue Premier. Submit the case as Express Issue Deluxe.

<b>A. In the past 2 years:</b>	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Diabetes requiring insulin treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. SLE (Systemic Lupus Erythematosus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been declined or postponed for Life Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>B.</b> If under age 65, are you currently disabled, or been disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>C.</b> Do you now participate in, or do you have plans to participate in any hazardous sport or aviation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 10 – Agreement/Acknowledgment**

I hereby apply for the insurance indicated above and I am submitting the first premium. I have read (or have had read to me) all statements and answers recorded on this application, and I certify that the answers are true and accurate whether written by my own hand or not. I understand that my policy will not be effective until the date it is issued by the company and the premium paid.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

**\*\*\*WARNING\*\*\***

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud, which is a crime.

I, the Proposed Owner, and Proposed Insured (if other than Proposed Owner), hereby certify under penalties of perjury, that the tax identification number provided is true, correct and complete.

**SECTION 11 – Authorization**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or other organization, institution, or person, that has any records or knowledge of me or my dependents, if they are to be insured, or our health, to give the United Home Life Insurance Company ("UHL") or its reinsurer(s) any such information. UHL may also disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for UHL or as may otherwise be legally allowed. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that UHL may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date of my signature below. I have a right to receive a copy of this authorization.

**SECTION 12 – HIPAA Authorization**

**This authorization complies with the HIPAA Privacy Rule.**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company and its agents, employees, and representatives. United Home Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Home Life Insurance Company or as may otherwise be legally allowed. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy, image, or facsimile of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I have a right to receive a copy of this authorization.

**SECTION 13 – Signatures**

**Signature applies to Sections 1 through 12. Review before signing.**

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
City State Month Year

Signature of Proposed Insured or personal representative (Must be signature of Proposed Insured for Graded Death Benefit Endowment)

Description of personal representative's authority to act

Signature of Owner (If other than Proposed Insured)

**THE FOLLOWING SECTION MUST BE COMPLETED BY THE AGENT.**

To the best of my knowledge and belief the insurance applied for herein is  is not  intended to replace or change any existing life insurance or annuity coverage.

If the application is being submitted for the Graded Death Benefit Endowment, I hereby affirm that I was personally present with the Proposed Insured when this application was completed, and: (1) the Proposed Insured is not confined to a hospital, hospice, nursing home, convalescent home, or does not require home health nursing care; (2) to my knowledge the Proposed Insured is not HIV+ or does not have AIDS or any terminal illness (any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months); and (3) I have no knowledge of intravenous drug abuse (IVDA) of the Proposed Insured.

X \_\_\_\_\_ X \_\_\_\_\_  
Printed Agent Name Agent's Signature

Agent Code \_\_\_\_\_ Agent's E-Mail \_\_\_\_\_

Agent: Phone # \_\_\_\_\_ Fax# \_\_\_\_\_ License Identification Number ( \_\_\_\_\_ )  
State

AUTHORIZATION TO HONOR CHECKS  
DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

The initial modal premium **must** be quoted in Section 5 of the application.  
We do not accept debit or credit cards.

**Please select ONLY one option. Include a copy of voided check for bank draft.**

- Draft my account for the first premium (initial premium may be drafted immediately upon submission of this application). Please draft subsequent premiums on the \_\_\_\_\_ day of each month.
  
- Draft my account for the first premium on: \_\_\_\_\_ . All subsequent drafts will occur on this same day each month.
  
- Do NOT draft my account for the first premium. The initial premium is attached, is being mailed, or will be collected on delivery. **Please make check or money order payable to United Home Life Insurance Company.** Do not leave Payee blank or make it payable to the agent. Please draft subsequent premiums on the \_\_\_\_\_ day of each month.

The policy may be placed on direct quarterly mode temporarily if we do not receive complete bank information or if there is a difference in premium quoted.

**I understand that my policy will not be effective until the policy is issued and premium paid.**

Bank Name \_\_\_\_\_ Bank Address \_\_\_\_\_

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that I am personally liable for overdraft fees charged on said account if funds are not available at the designated date of withdrawal. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry. I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account Number: \_\_\_\_\_  Checking  Savings Routing Number: \_\_\_\_\_

Premium Payor's Printed Name: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Signature of Premium Payor: \_\_\_\_\_ Date: \_\_\_\_\_

**In the event that a pre-printed void check or bank statement is not available, please complete the following information for account verification:**

Financial Institution: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

I have personally verified that the above policy owner/payor has a current, active account.

Agent Name: \_\_\_\_\_ Agent #: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE DETACH AND GIVE TO APPLICANT**

*If you do not receive your Policy within 60 days from the date of your application,  
please write to UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192*

**UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)**

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

I understand that my policy will not be effective until the date it is issued by the company.

**RECEIPT**

Received from \_\_\_\_\_ The sum of \$ \_\_\_\_\_

Being the 1st premium of \_\_\_\_\_ mode

Type of proposed insurance \_\_\_\_\_ Amount of proposed insurance \$ \_\_\_\_\_

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_  
Month Day Year

Agent Signature \_\_\_\_\_

**FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE**

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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 office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life 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](http://www.mib.com).

**IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION**

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.



**UNITED HOME LIFE INSURANCE COMPANY**  
**P.O. Box 7192**  
**Indianapolis, IN 46207-7192**  
**Phone: (317) 692-7979 Fax: (317) 692-7711**

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE**

It is in your best interest to get all the facts before making a decision. Make sure you fully understand both the proposed new policy and your existing insurance. New policies may contain provisions which limit benefits during the initial period of the contract, in particular, the suicide and incontestable clauses.

To assist you in evaluating the proposed and the existing insurance, Delaware Insurance Regulation 30 requires that the insurer advising or recommending replacement:

Provide the consumer, not later than the date the policy or contract is delivered, a concise summary of the policy or contract to be issued.

Allow a twenty day period following the delivery of the policy during which time the consumer may surrender the new policy for a full refund.

Advise the present insurance company(s) of the pending replacement.

This same regulation requires your present insurer to provide, on your request, a similar summary describing your present insurance. This information will be provided if you request it using the form below.

**INFORMATION ON PRESENT POLICIES**

<b>Company Name</b>	<b>Policy Number</b>	<b>Name of Insured</b>	<b>Summary Requested Mark Yes or No</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**IT IS SELDOM WISE TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT TO BE ACCEPTABLE.**

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

\_\_\_\_\_  
 Applicant's Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
 Agent's Signature \_\_\_\_\_  
Date

Agent's Name and Address (printed) Company Name

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_



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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

\_\_\_\_\_  
 Applicant's Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
 Agent's Signature \_\_\_\_\_  
Date

Agent's Name and Address (printed) Company Name

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_



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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**IT IS SELDOM WISE TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT TO BE ACCEPTABLE.**

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

\_\_\_\_\_  
 Applicant's Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
 Agent's Signature \_\_\_\_\_  
Date

Agent's Name and Address (printed) Company Name

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_



**United Home Life Insurance Company**  
**P.O. Box 7192 • Indianapolis, Indiana 46207-7192**

**NOTICE AND CONSENT FOR ORAL FLUID AND/OR BLOOD WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING**

To determine your insurability, the Insurer named above may request that you provide a sample of your urine, oral fluid, and/or blood for testing and analysis. All tests will be performed by a licensed laboratory selected by the insurer at no cost to you. The consent you give by signing this form authorizes the insurer to obtain urine, oral fluid, and/or withdraw blood and order laboratory tests only in regard to your present application for life or disability income insurance.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that is performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Occasionally, however, false results may occur. A false positive is very rare, and is most common in persons who have not engaged in high risk behavior. False negative results occur most commonly in recently infected persons; it takes 4-12 weeks for a positive result to develop after a person is infected. Other tests which may be performed include, but are not limited to, determinations of blood cholesterol and related lipids (fats) and screening for liver and kidney disorders, diabetes, and immune disorders, and the presence of nicotine, certain prescription medications and drugs of abuse.

The urine and oral fluid tests are optional. Urine and oral fluid tests are less reliable than blood tests to determine HIV status. You may choose instead to consent to the withdrawal of a sample of your blood. No adverse underwriting decision will be made on the basis of reactive HIV-related tests unless based on an approved testing protocol including, but not limited to, two reactive enzyme-linked immunosorbent assays (ELISA) tests, followed by confirmatory Western Blot Testing.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees, or contractors. If a sample of your urine or oral fluid is tested to determine the presence of HIV, the insurer may at a later time request a specimen of your blood for further HIV testing. The results of any test of oral fluids for the presence of HIV will not be reported to MIB, Inc. or any other person or entity. All abnormal blood test results for HIV antibodies/antigens will be reported to MIB, Inc., by a generic code which signifies only a non-specific blood test abnormality. If the HIV test is normal, no report will be made about it to the MIB, Inc. Other non HIV-related test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you, including but not limited to the release of information to the Department of Health Services as may be provided by law.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the insurer will contact you. The insurer may also contact you if there are other abnormal test results which, in the insurer's opinion, are significant. The insurer will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. Reactive (positive) HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Reactive (positive) HIV antibody or antigen test results or other significant oral fluid or blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I have read and I understand this Notice and Consent for Oral Fluid And/Or Blood Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily submit an oral fluid specimen and/or consent to the withdrawal of blood from me by needle, the testing of that oral fluid and/or blood, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This authorization will be valid for up to two (2) years from the date signed.

\_\_\_\_\_ Proposed Insured \_\_\_\_\_ Date of Birth

Name and address of designated Physician:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Signature of Proposed Insured or Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ State of Resident

## **HIV INFORMATION FORM FOR INSURANCE APPLICANT**

### **ABOUT AIDS**

Acquired Immunodeficiency Syndrome (AIDS) is a life threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use).

AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Symptoms of infection may include fever, weight loss for no apparent reason, swollen lymph glands, fatigue, diarrhea, or white spots or blemishes in the mouth.

### **HIV TESTING AND RESULTS**

There are tests that determine the presence of antibodies or antigens to HIV. These tests do not test for AIDS; AIDS can only be diagnosed by medical evaluation.

A positive test result means that a person may be infected with HIV.

A person with a positive test should:

- Have a regular medical checkup and get counseling.
- Not donate blood, sperm or organs.
- Not share needles with others.
- Avoid exchanging body fluids during sexual activity.
- Not share toothbrushes, razors or anything that could be contaminated with blood.

A negative test result is not a guarantee that a person is not infected. It takes several weeks for a positive test result to develop after a person is infected. Persons with a negative test result should begin, or continue, to practice safe sex (including condom use for sexual contact with someone other than a long-term monogamous partner) and not engage in high risk behavior, such as sharing needles.

### **INFORMATION AND COUNSELING RESOURCES**

Further information about HIV testing and AIDS can be obtained by calling the following AIDS hotline:

National AIDS Hotline 1-800-342-AIDS



## Authorization for Release of Medical Information

United Home Life Insurance Company  
P.O. Box 7192, Indianapolis IN 46207-7192

**This authorization complies with the HIPAA Privacy Rule.**

\_\_\_\_\_  
Name of proposed insured/patient **(please type or print)**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

**I authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (“My Providers”) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative’s Authority or Relationship to Patient



**UNITED HOME LIFE INSURANCE COMPANY**  
 P.O. Box 7192  
 Indianapolis, IN 46207-7192  
 Phone: (317) 692-7979 Fax: (317) 692-7711

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE**

It is in your best interest to get all the facts before making a decision. Make sure you fully understand both the proposed new policy and your existing insurance. New policies may contain provisions which limit benefits during the initial period of the contract, in particular, the suicide and incontestable clauses.

To assist you in evaluating the proposed and the existing insurance, Delaware Insurance Regulation 30 requires that the insurer advising or recommending replacement:

Provide the consumer, not later than the date the policy or contract is delivered, a concise summary of the policy or contract to be issued.

Allow a twenty day period following the delivery of the policy during which time the consumer may surrender the new policy for a full refund.

Advise the present insurance company(s) of the pending replacement.

This same regulation requires your present insurer to provide, on your request, a similar summary describing your present insurance. This information will be provided if you request it using the form below.

**INFORMATION ON PRESENT POLICIES**

<b>Company Name</b>	<b>Policy Number</b>	<b>Name of Insured</b>	<b>Summary Requested Mark Yes or No</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**IT IS SELDOM WISE TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT TO BE ACCEPTABLE.**

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

\_\_\_\_\_  
 Applicant's Signature \_\_\_\_\_  
Date

\_\_\_\_\_  
 Agent's Signature \_\_\_\_\_  
Date

Agent's Name and Address (printed) Company Name  
 \_\_\_\_\_  
 \_\_\_\_\_