

## Whole Life Express



### Application Submission Checklist (Please submit with 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 and legibly.
  - 2 Be sure the application is signed and dated in all places indicated by the Proposed Insured(s) and the applicant if other than the Proposed Insured.
  - 3 Any changes should be initialed by the Proposed Insured(s) and, if applicable, the Applicant.
  - 4 Use age last birthday.
  - 5 See reverse side of this page for additional detailed information.
- Have Client sign 'Authorization to Disclose Personal Information' (HIPAA Authorization) and submit with application.\***
- Provide Client with MIB Group, Inc. Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Investigative Consumer Reports Notice, Summary of Rights and Buyer's Guide**
- Collect Premium Amount**
  - 1 Full modal premium is to be collected at the time of application.
  - 2 If the Bank Service Plan (BSP) is selected, complete the BSP authorization and collect two (2) months premium.
- Have Client sign 'Conditional Receipt' and submit with application**
- Have Client sign any state specific forms, if applicable**
- Have Client Sign any state replacement forms (if applicable) and provide copy to client**
- Attach copy of the Cover Letter (if appropriate)**
- Financial Institution Consumer Disclosure**

If this insurance product or annuity is sold, solicited, advertised or offered to a customer at an office of the financial institution, or on behalf of the financial institution, the "Financial Institution Consumer Disclosure" form must be presented and signed at the time of application, and a copy provided with the submitted application.

Activities on behalf of a financial institution include activities where a person, whether at the office of the financial institution or at another location, sells, solicits, advertises, or offers an insurance product or annuity and at least one of the following applies:

  - The person represents to a consumer that the sale, solicitation, advertisement or offer of any insurance product or annuity is by or on behalf of the financial institution,
  - The financial institution refers a consumer to a seller of insurance products and annuities and the financial institution has a contractual arrangement to receive commissions or fees derived from a sale of an insurance product or annuity resulting from that referral, or
  - Documents evidencing the sale, solicitation, advertising, or offer of an insurance product or annuity identify or refer to the financial institution.

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



## Life Insurance Application

### Section A PROPOSED INSURED INFORMATION

Name (First, Middle Initial, Last) \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Social Security Number - -	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Age	Telephone Number ( ) -
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Secondary Addressee Information. Please provide name and address (A copy of any notification of possible policy lapse will be sent to this person) (Optional)

Are you a citizen of the United States?.....  Yes  No

**(If "No," complete Foreign National and Foreign Travel Questionnaire and list details below.)**

Documentation (select one):  Permanent Resident Card (Card number \_\_\_\_\_)

Visa (specify type \_\_\_\_\_)

Date of Arrival in the United States: \_\_\_\_\_ / \_\_\_\_\_

### Owner/Applicant Information (Complete only if Owner/Applicant is different from Proposed Insured)

Owner's Name (First, Middle Initial, Last) \_\_\_\_\_

Owner's Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Social Security Number - -	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Age	Telephone Number ( ) -
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Relationship to Proposed Insured \_\_\_\_\_

Are you a citizen of the United States?.....  Yes  No

**(If "No," complete Foreign National and Foreign Travel Questionnaire and list details below.)**

Documentation (select one):  Permanent Resident Card (Card number \_\_\_\_\_)

Visa (specify type \_\_\_\_\_)

Date of Arrival in the United States: \_\_\_\_\_ / \_\_\_\_\_

### Section B UNDERWRITING INFORMATION (Complete if applying for Whole Life Express)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Birth State \_\_\_\_\_

Driver's License Number/State of Issue \_\_\_\_\_

In the past 12 months, has the proposed insured used any form of tobacco or nicotine replacement therapy? .....  Yes  No

### IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN SECTION B, THAT PERSON IS NOT ELIGIBLE FOR WHOLE LIFE EXPRESS COVERAGE.

		Yes	No
1. Has the Proposed Insured <b>ever</b> been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection or been treated for AIDS, ARC, or HIV by a physician or health care provider? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the Proposed Insured <b>currently</b> :			
(a) bedridden or confined to any hospital, nursing home, or other medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) using any of the following: wheelchair, electric scooter, oxygen or catheter? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 6 months, has the Proposed Insured:			
(a) required the assistance of another person, or a device of any kind for: bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) received, or been advised to have, any of the following: care in a nursing home, assisted living facility, adult day care facility; or home health care services?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Section B**

**UNDERWRITING INFORMATION – continued**

4. Has the Proposed Insured <b>ever</b> (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for, or (c) consulted with a health care provider regarding:	<b>Yes</b>	<b>No</b>
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease or Replacement, Cardiomyopathy, Congenital Heart Disease, Stroke, or Cerebral or Symptomatic Aneurysm? .....	<input type="checkbox"/>	<input type="checkbox"/>
(b) Chronic Lung Disease (except mild Asthma), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis? .....	<input type="checkbox"/>	<input type="checkbox"/>
(c) Bipolar Depression, Schizophrenia, Alzheimer’s Disease, Dementia, Parkinson’s Disease, Demyelinating Disease including Multiple Sclerosis; Huntington’s Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down’s Syndrome or any other disease of the central nervous system?.....	<input type="checkbox"/>	<input type="checkbox"/>
(d) Chronic Kidney Disease, end-stage Renal Disease with dialysis or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C? .....	<input type="checkbox"/>	<input type="checkbox"/>
(e) Diabetes with onset before age 50 or with vascular or renal complications? .....	<input type="checkbox"/>	<input type="checkbox"/>
(f) an organ transplant? .....	<input type="checkbox"/>	<input type="checkbox"/>
(g) Systemic lupus or Scleroderma? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. <b>In the past 10 years</b> , has the Proposed Insured:		
(a) been treated or advised to be treated for alcoholism, alcohol use, or any drug/substance use? .....	<input type="checkbox"/>	<input type="checkbox"/>
(b) been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had 4 or more moving violations?.....	<input type="checkbox"/>	<input type="checkbox"/>
(c) been convicted of a felony? .....	<input type="checkbox"/>	<input type="checkbox"/>
(d) been hospitalized for high blood pressure or any mental or nervous disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
(e) been treated or advised to be treated for Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell skin cancer)? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. <b>In the next 2 years</b> , will the Proposed Insured engage in any motor sports racing or activities, boat racing, parachuting, hang gliding, rock or mountain climbing, or skydiving? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. <b>In the past 12 months</b> , has the Proposed Insured been advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes, treatment, or other procedure which has not been done? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. <b>In the past 12 months</b> , has the Proposed Insured consulted a physician for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding? .....	<input type="checkbox"/>	<input type="checkbox"/>

**Section C PLAN AND BENEFICIARY INFORMATION**

**Plan Information**

Whole Life Express

Face Amount \$ \_\_\_\_\_ Modal Premium \$ \_\_\_\_\_ Amount Collected \$ \_\_\_\_\_

**Beneficiary Information**

Primary Beneficiary Name	Contingent Beneficiary Name
Relationship	Relationship
Social Security Number                    -                    -	Social Security Number                    -                    -

**Section D OTHER COVERAGE AND REPLACEMENT INFORMATION**

- List below all life insurance policies and/or annuity contracts on the Proposed Insured 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
- Have you had, or do you intend to have, any existing 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,” complete 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 or Converted?	Assigned or Sold?
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section E****BILLING INFORMATION**

Method of Payment:  Annual  Semiannual  Quarterly  
 Monthly Bank Service Plan (select one below)

**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.

By signing below, I/We authorize renewal premiums to be automatically paid to United of Omaha, by electronic fund transfer, from the bank account identified below and on the date specified below. 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.

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

Authorized Signature as shown on account \_\_\_\_\_

Social Security Number of Payor \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

**Section F****PLEASE READ AND SIGN****If applying for Whole Life Express:****AUTHORIZATION TO RECEIVE INFORMATION FROM AND DISCLOSE INFORMATION TO THE MIB GROUP, INC. (MIB):**

**The MIB Group, Inc. (MIB)** is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

**“Personal Information”** means information about me, including health information such as medical history, mental and physical condition, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claim information.

To the MIB: I authorize you to disclose Personal Information about me to United of Omaha Life Insurance Company, its representatives and its reinsurers. You are not authorized to disclose Personal Information about me to a consumer reporting agency. The Personal Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance.

I also authorize United of Omaha Life Insurance Company and its reinsurers to disclose Personal Information about me to the MIB. I understand that the Personal Information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I submit a claim for benefits.

Unless revoked earlier, this authorization will remain in force for 24 months from the date below. A copy of this authorization is as effective as the original.

**Continued on next page**

**Agreement:**

I, the Undersigned, and the undersigned Producer(s), represent that we have read the completed application, or have had it read to us, and agree to the following:

1. **All answers in this application (a) are true and complete; (b) will be relied on to determine insurability; and (c) which are incorrect or misleading, may void this application and any issued policy effective the issue date.**
2. Except for coverage provided under the terms of a Conditional Receipt, if issued, the life insurance policy applied for will not take effect until it is issued by us and all of the following requirements are met: (a) the policy is delivered to and accepted by the policyowner; (b) the first full premium has been paid according to the mode of payment specified in the application; (c) the Proposed Insured is still alive; and (d) there has been no change in the Proposed Insured’s health or habits, or the answers to any of the questions in the application, from the date the application is approved by United of Omaha’s Underwriting Department to the date the policy is delivered and accepted by the policyowner.
3. In no event will benefits be paid for the same loss under both a Conditional Receipt and any policy issued from this application.
4. If the Applicant is other than the Proposed Insured, the Applicant will own the policy.
5. No Producer can: (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
6. REQUESTED POLICY ISSUE DATE (if applicable). \_\_\_\_\_

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**If applying for Whole Life Express:** I have received the MIB Group, Inc. Pre-Notice, the Notice of Information Practices, and a Life Insurance Buyer’s Guide before completing this application.

I approve the answers to the questions in this application as recorded.

**I have read and understand the Authorization to Receive Information From and Disclose Information to the MIB Group, Inc. (MIB) and the Agreement Section.**

Signed at: \_\_\_\_\_ Date: \_\_\_\_\_  
City State

\_\_\_\_\_  
Signature of Proposed Insured (Age 18 and Older)

\_\_\_\_\_  
Signature of Parent or Guardian (if Proposed Insured under age 18)

\_\_\_\_\_  
Signature of Applicant/Owner/Trustee (if other than Proposed Insured)

**Producer Statement:**

In addition to the above, by signing below, I/we, the Producer(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

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

Has the Proposed Insured informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? .....  Yes  No

**(If either question is answered “Yes,” fulfill all state and company requirements.)**

\_\_\_\_\_  
Signature of Producer #1 Production Number Date

\_\_\_\_\_  
Signature of Producer #2 Production Number Date

\_\_\_\_\_  
Print or Stamp Producer #1 Name Print or Stamp Producer #2 Name Agency Name

## Authorization To Disclose Personal Information To United of Omaha Life Insurance Company

### Meanings of Terms

**“Medical Persons and Entities” means:** all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

**“Personal Information” means:** all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

**“Psychotherapy Notes” means:** notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

**“Specified Companies” means:**

- The group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, Exclusive Healthcare, Inc., additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

### Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to United of Omaha Life Insurance Company.

### Purposes

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

### Potential For Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

### Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

### Expiration and Revocation

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:

ATTN: Individual Underwriting  
United of Omaha Life Insurance Company  
Mutual of Omaha Plaza  
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that United of Omaha Life Insurance Company has taken action in reliance on the authorization or the law allows United of Omaha Life Insurance Company to contest the issuance of the policy or a claim under the policy.

### Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

### Names and Signatures

Name(s) used for medical records (if different than the name(s) below): \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Proposed Insured

\_\_\_\_\_  
Spouse’s Printed Name  
(If Proposed Insured)

\_\_\_\_\_  
If children are to be insured, their printed names

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Spouse  
(If Proposed Insured)

\_\_\_\_\_  
Signature of Parent or Guardian  
(If Proposed Insured is a Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS**

## **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 (TTY 866-346-3642). 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: Post Office Box 105, Essex Station, Boston, MA 02112.

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.

## **Fair Credit Reporting Act Disclosure Statement**

Mutual of Omaha Insurance Company and/or United of Omaha Life Insurance Company, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights under Section 609 (c) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address: Attention: Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, Nebraska 68175.

## **United of Omaha Life Insurance – Notice of Information Practices**

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

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

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

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

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

## **Investigative Consumer Reports Notice**

United of Omaha Life Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

**GIVE THIS NOTICE TO THE APPLICANT**

## A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to [www.ftc.gov/credit](http://www.ftc.gov/credit) or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See [www.ftc.gov/credit](http://www.ftc.gov/credit) for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to [www.ftc.gov/credit](http://www.ftc.gov/credit).
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).

**GIVE THIS NOTICE TO THE APPLICANT**

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit [www.ftc.gov/credit](http://www.ftc.gov/credit).

**States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:**

**TYPE OF BUSINESS:**

Consumer reporting agencies, creditors and others not listed below

National banks, federal branches/agencies of foreign banks (word “National” or initials “N.A.” appear in or after bank’s name)

Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)

Savings associations and federally chartered savings banks (word “Federal” or initials “F.S.B.” appear in federal institution’s name)

Federal credit unions (words “Federal Credit Union” appear in institution’s name)

State-chartered banks that are not members of the Federal Reserve System

Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission

Activities subject to the Packers and Stockyards Act, 1921

**CONTACT:**

Federal Trade Commission: Consumer Response Center - FCRA  
Washington, DC 20580  
1-877-382-4357

Office of the Comptroller of the Currency  
Compliance Management, Mail Stop 6-6  
Washington, DC 20219  
800-613-6743

Federal Reserve Board  
Division of Consumer & Community Affairs  
Washington, DC 20551  
1-202-452-3693

Office of Thrift Supervision  
Consumer Complaints  
Washington, DC 20552  
1-800-842-6929

National Credit Union Administration  
1775 Duke Street  
Alexandria, VA 22314  
1-703-519-4600

Federal Deposit Insurance Corporation  
Consumer Response Center, 2345 Grand Avenue, Suite 100  
Kansas City, Missouri 64108-2638  
1-877-275-3342

Department of Transportation , Office of Financial Management  
Washington, DC 20590  
1-202-366-1306

Department of Agriculture  
Office of Deputy Administrator - GIPSA  
Washington, DC 20250  
1-202-720-7051

**Division Office/Brokerage General Agency/Bank Information**

Printed Name of Producer/Production No.

Printed Name of Producer/Production No.

Commission % Share

Commission % Share

Phone No.

Phone No.

E-Mail Address

E-Mail Address

Date

Date

Reviewed By:

(Division Office, BGA, Bank Name)

(DSM, Assistant Wholesaler or Authorized Reviewer's Printed Name)

Agency Stamp

DSM Stamp

# Conditional Receipt

United of Omaha Life Insurance Company  
Omaha, Nebraska

(Select one below.)

**Initial Premium paid by Electronic Funds Transfer**

No money was collected with the application on \_\_\_\_\_  
(person(s) proposed for insurance)

**Initial Premium paid by check**

Money was collected - Received \$ \_\_\_\_\_ from \_\_\_\_\_ paid with a life insurance  
application on \_\_\_\_\_, dated \_\_\_\_\_  
(person(s) proposed for insurance)

**(ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO UNITED OF OMAHA LIFE INSURANCE COMPANY ("UNITED OF OMAHA"). DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.)**

This Conditional Receipt will provide limited insurance coverage for each person proposed for insurance, subject to all of the provisions of the policy(ies) applied for, as of the application date, but only if **all** of the following conditions have been completely met:

- (i) payment of the full first premium according to the method of payment selected in the application;
- (ii) 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 of Omaha then in force, without modification of the plan, premium rate, benefits, class and amount of coverage applied for; and
- (iii) all of the statements and answers in the application are true and complete when made, and there is no material misrepresentation in the application furnished to United of Omaha.

If (a) any of the above conditions are not exactly met, or (b) the above conditions are exactly met but the person proposed for insurance dies by suicide, whether sane or insane (except in Colorado and Missouri), or (c) the application is not accepted by United of Omaha, no insurance coverage will be provided under this Conditional Receipt, and United of Omaha's only liability will be to notify the applicant in writing and return the premium paid.

**For each person proposed for insurance**, the maximum death benefit payable under this Conditional Receipt will be the lesser of: (a) the total death benefit payable under all Receipts and all pending applications with United of Omaha relating to the person proposed for insurance, or (b) \$50,000. This Receipt provides no coverage for policy Riders.

If each person proposed for insurance choose(s) to pay the full initial premium by electronic funds transfer, he/she/they understand and agree that the full initial premium will not be considered to be paid by United of Omaha until it is received by United of Omaha.

Regardless of any other provision of this Conditional Receipt, any coverage that becomes effective under this Conditional Receipt will terminate on the earliest of the following: (a) the effective date of a policy issued as a result of this application; (b) the date United of Omaha mails notice that the coverage applied for will not be issued and refunds any premium paid; or (c) 60 days following the date of the application. Either United of Omaha or the person proposed for insurance may terminate this Conditional Receipt as to such person by providing written notice to the other party.

In no event will benefits be paid for the same loss under both this Conditional Receipt and any life insurance policy issued from the application.

No producer is authorized to alter the terms of this Receipt, waive any representations, or pass on insurability

I understand and agree to the terms, conditions and limitations of this Conditional Receipt and the Agreement section of the application. These have been fully explained to me by the Producer.

Date: \_\_\_\_\_

Signed at: \_\_\_\_\_  
City State

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Other Proposed Insured (if applying for insurance)

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Signature of Producer

# Conditional Receipt

United of Omaha Life Insurance Company  
Omaha, Nebraska

(Select one below.)

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Date: \_\_\_\_\_

Signed at: \_\_\_\_\_  
City State

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Other Proposed Insured (if applying for insurance)

\_\_\_\_\_  
Signature of Producer

\_\_\_\_\_  
Signature of Producer