UNITED LIFE
INSURANCE COMPANY

Application for Individual Life Insurance
Single Premium Whole Life
Limited-Pay Whole Life
Traditional Whole Life Insurance
Including an option to apply for an individual long-term care insurance rider

PROPOSED INSURED
Name (Last, First, Middle) _____ U.S. Citizen ❑ Yes ❑ No
Street Address _____ City _____ State_____ Zip _____
Soc.Sec. # _____ Dr. Lic. # and State _____
❑ Male ❑ Female Date of Birth _____ Age _____ Place of Birth _____
Occupation _____ Employer _____
Contact Phone _____ Cell Phone _____ Email _____
Other Life Insurance in force? ❑ Yes ❑ No With United Life? $ _____ With other companies? $ _____
RATE CLASS ❑ **PREFERRED** (Minimum $100,001 face amount. No tobacco or nicotine products for 24 months.)
❑ **SELECT** (No cigarettes for 12 months, other tobacco or nicotine products acceptable) ❑ **STANDARD** (Cigarette smoker)

Owner (if different) _____ Date of Birth _____ Phone _____
Street Address _____ City _____ State_____ Zip_____
Relationship to the proposed insured _____ ❑ Individual ❑ Corp ❑ LLC ❑ Partnership ❑ Other
Tax ID/SS # _____ U.S. Citizen ☐ Yes ☐ No Email _____
If a Trust, POA or Corporation is the Owner, must submit copy of Trust Agreement, POA documents or Corporate Resolution
Contingent Owner (Required if proposed insured is a minor) _____
Payor Name (if different than owner) _____ Tax ID/SS Number _____
Billing Address _____ City _____ State _____ Zip _____ U.S. Citizen ❑ Yes ❑ No
Email _____

FACE AMOUNT $_____ ***MUST SUBMIT PROPOSAL WITH APPLICATION***

Plan

❑ **Single Premium Whole Life**

❑ **Traditional Whole Life** ❑ **5-Pay Whole Life** ❑ **10-Pay Whole Life** ❑ **20-Pay Whole Life**

❑ Disability Waiver Rider
❑ QCADB* Rider ..... $ _____ Category A Monthly Benefit ❑ 2% ❑ 3% ❑ 4% ❑ 5%
Qualified Care Accelerated Death Benefit Minimum $50,000 Must complete page 5 for QCADB.

Other riders for Traditional Whole Life only

❑ Children's Term Rider ..... $ _____ Must complete child rider supplemental app.

Premium/Payment Mode

Annual Premium $_____
Cash with App..... ☐ Yes ☐ No $_____
1035(a) Exchange?..... ☐ Yes ☐ No $_____
COD?..... ☐ Yes ☐ No
❑ Collect Annual Premium From New Income Annuity for duration of premium paying period (5, 10, or 20 pay)
❑ New Income Annuity Policy Premium $ _____

❑ **Bank Withdrawal** (EFT) Draft Date **MM/DD** _____
❑ Monthly Bank Withdrawal ❑ Quarterly Bank Withdrawal
(Submit a voided check or United Life Bank Withdrawal Form)
❑ **Draft initial premium**.
(If Unchecked & initial premium has not been received, a bill will be mailed for initial premium)
❑ Mail Bill to payor? ❑ Mo ❑ Qtly ❑ SA ❑ Ann. or Single Prem.

When we use the words “you” or “your” in this application, we mean Proposed Insured.

If the Proposed Insured answers ‘Yes’ to any question 1-7, *policy will not be issued*.	**Yes**	**No**
1. Are you waiting for a medical diagnosis or medical test result from a member of the medical profession or within the last five years have you been advised by a member of the medical profession to have surgery requiring general anesthesia that has not been completed? This question does not apply to tests for the Human Immunodeficiency Virus (AIDS virus).	❑	❑
2. Do you require or have you been advised to receive human assistance or supervision with the following activities: eating, dressing, toileting, transferring from bed to chair, walking, maintaining continence, bathing or taking medication; or do you use oxygen equipment to assist in breathing, or are you currently receiving kidney dialysis?	❑	❑
3. During the past 18 months, have you been diagnosed by a member of the medical profession with a terminal illness expected to result in death within 12 months?	❑	❑
4. Have you ever been diagnosed by a member of the medical profession with Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC) or tested positive to Human Immunodeficiency Virus (HIV)?	❑	❑
5. Have you been diagnosed, treated or prescribed medication by a member of the medical profession for Alzheimer’s disease or any other type of dementia?	❑	❑
6. Have you ever been advised by a member of the medical profession to have a liver, heart, lung or other internal organ transplant (excluding kidney)?	❑	❑
7. Are you currently incarcerated, on parole or probation?	❑	❑

8. Proposed Insured’s Current Height _____ and Current Weight _____

9. Do you currently smoke cigarettes? ☐ Yes ☐ No

   Have you smoked cigarettes within the past 12 months? ☐ Yes ☐ No

   Have you smoked cigarettes within the past 24 months? ☐ Yes ☐ No

10. Confirm other tobacco and/or nicotine products used in the past 24 months.

    ❑ None ❑ Pipe ❑ Cigar ❑ Chew ❑ Gum ❑ Patch ❑ E-cigarette ❑ Other _____

11. List all prescription medications you have taken in the past 12 months, the reason for the prescription and the dosage. Use an additional, signed and dated sheet of paper if needed.

Prescription Drug	Dosage	Reason Prescribed

12. Provide name, address and phone number of your primary health care provider seen in the last 5 years, along with the date and reason last seen and the results of the last visit.

Dr. Name _____ Phone _____

Address _____

Date and reason last seen: _____

Results of visit: _____

13. **Within the past 5 years** have you been diagnosed with, treated for or been given advice by a member of the medical profession for any of the following diseases, illnesses or impairments? ***Check all conditions that apply***. Provide details to all choices in the Details section below.

a. Cancer/Carcinoma
- ❑ Internal Cancer, any type
- ❑ Leukemia
- ❑ Melanoma

b. Cardiovascular/ Cerebrovascular
- ❑ Angina (Chest Pain)
- ❑ Arrhythmia (Irregular heart rhythm)
- ❑ Atrial Fibrillation
- ❑ Cardiomyopathy
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ Heart Failure
- ❑ Heart Surgery
- ❑ High Blood Pressure (Hypertension)
- ❑ Stroke
- ❑ Transient Ischemic Attack (TIA)
- ❑ Valvular Heart Disease

c. Circulatory
- ❑ Atherosclerosis
- ❑ Peripheral Arterial Disease
- ❑ Peripheral Vascular Disease

d. Endocrine and Renal Disorders
- ❑ Diabetes
- ❑ Chronic Kidney Disease
- ❑ Kidney failure

e. Gastrointestinal
- ❑ Chronic Hepatitis
- ❑ Cirrhosis
- ❑ Liver Disease

f. Lifestyle/Miscellaneous
- ❑ Alcoholism/Alcohol Abuse
- ❑ Drug Addiction
- ❑ Systemic Lupus

g. Musculoskeletal
- ❑ Arthritis
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Paralysis

h. Neurological
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease

i. Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Post Traumatic Stress Disorder (PTSD)
- ❑ Schizophrenia

j. Respiratory
- ❑ Asthma
- ❑ Chronic Bronchitis
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Emphysema
- ❑ Sleep Apnea

	Yes	No
14. Within the past five years have you been diagnosed with, treated for or been given advice by a member of the medical profession for any reason not already identified above?	☐	☐
15. Has your driver's license ever been suspended or revoked? Have you ever pleaded guilty to or been convicted of driving while impaired, intoxicated or under the influence of any drug? During the past five (5) years have you pleaded guilty to or been convicted of any moving violation or been involved in any accident in which you were found to be at fault?	☐	☐
16. Have you ever flown, or intend within the next two (2) years to fly, other than as a fare-paying passenger on a scheduled airline? (If yes, please complete the Aviation Questionnaire)	☐	☐
17. Have you ever or do you intend within the next two (2) years to engage in motor sports events or racing; rock or mountain climbing; skin or scuba diving; or aeronautics (hang-gliding, sky diving, parachuting, ultralight, soaring, ballooning) or back country skiing?	☐	☐
18. Have you ever pleaded guilty to or been convicted of a felony or misdemeanor or do you have such a charge currently pending against you?	☐	☐
19. Have you ever had life or health insurance declined, modified or rated? If 'yes,' when & why?	☐	☐

20. DETAILS. **Explain any "yes" answers and checked conditions above.** Include the specific impairment and reference the question number for which you are providing details. Provide impairment details, dates of diagnosis, etc. Incomplete information may require completion of additional questionnaires. Additional details can be provided on a separate signed and dated sheet of paper.

BENEFICIARY DESIGNATION (will be Revocable and Per Stirpes if not indicated.)
If premium is being paid from a new income annuity, the beneficiaries designated below will be the same beneficiaries for Income Annuity.
PER STIRPES—if a named beneficiary dies before the insured, proceeds will be paid to the surviving direct descendants of that beneficiary.
PER CAPITA—if named beneficiary dies before the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

If there are more beneficiaries, include the information below on a separate page. It must be signed and dated by the owner(s)

Primary ☐ Revocable or ☐ Irrevocable
☐ Per Stirpes or ☐ Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____
_____

2. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____
_____

3. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____
_____

Contingent ☐ Revocable or ☐ Irrevocable
☐ Per Stirpes or ☐ Per Capita

1. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____
_____

2. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____
_____

3. Name _____
Relationship _____
SS# _____ Birthday _____
Address _____
_____

ASSIGNMENT Is this policy assigned? ☐ Yes ☐ No
If yes, must attach a completed assignment form in order for assignment to be effective for this policy.

SUITABILITY

	Yes	No
1. Is the proposed insured or the owner planning to enter into any arrangement to pay the premiums due under this policy?	☐	☐
2. Does the proposed insured or owner intend to sell or transfer any interest in any policy issued as a result of this application?	☐	☐

Explain any "YES" answers. Provide details, dates, etc.

_____
_____
_____
_____
_____

3. Do you have existing life insurance or annuity contracts with this or any other company?	☐	☐
4. Is this insurance intended to replace existing life insurance or annuity with this or any other company? **If yes to either question, complete the replacement form as required by state law and submit it with this application.**	☐	☐

IRS Taxpayer Certification Under penalties of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

Medical Authorization I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, pharmacy benefit manager, insurance company, insurance support organization, employer, or the MIB Inc., formerly known as the Medical Information Bureau, Inc., to give United Life Insurance Company, or its reinsurers, all information from the past 10 years that it holds, that pertains to medical consultations, treatments, prescription records, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. I authorize United Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. The MIB is a not for profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This authorization shall be valid for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at PO Box 729 Cedar Rapids, Iowa 52406-0729. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United Life 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 redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United Life may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this Authorization and I agree that a photocopy of this Authorization shall be as valid as the original.

Acknowledgement I (we) have read this application in its entirety. I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.

City and State where signed _____ **Date** _____

X_____

SIGNATURE OF PROPOSED INSURED
(or parent if Proposed Insured is a minor)

X_____ **X** _____

SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED

I, the AGENT, certify that I have used only insurer-approved or provided sales material. I also certify that I have left a copy of all sales material, replacement forms and disclosures with the applicant.

Are there existing life insurance or annuity contracts on the life of the insured? ☐ Yes ☐ No

Is this policy intended to replace existing insurance or annuity with this or any other company? ☐ Yes ☐ No

I certify that I have seen a government issued ID to confirm the identity of the insured. ☐ Yes ☐ No

_____ _____

SIGNATURE OF AGENT AGENT'S PRINTED NAME

_____ _____% _____ _____%

AGENCY NAME AGENCY NUMBER AGENCY NAME AGENCY NUMBER

Date _____

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

UNITED LIFE
INSURANCE COMPANY

NOTICES TO APPLICANTS

AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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, the MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from the proposed insured(s), MIB will arrange disclosure of any information it may have on file. Please contact MIB at 866-692-6901. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

United Life Insurance Company or its reinsurers may also release information in their 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. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at www.mib.com.

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