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:
(FedEx or UPS Recommended)
United Home Life Insurance Company
225 South East St.
Indianapolis, IN 46202

_____ # pages including cover
Fax only once.

Agent Name:_____ Agent #: _____

Agent Phone:_____ Agent Fax: _____

Agent Email Address: _____

Is this a split commission case? ☐ Yes ☐ No If Yes, provide the information below.

Agent Name:_____ Agent #: _____ Percentage: _____

Agent Name:_____ Agent #: _____ Percentage: _____

Proposed Insured's Name: _____

Do you personally know the Proposed Insured? ☐ Yes ☐ No

Have you written insurance on the Proposed Insured in the past 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 Owner and/or Proposed Insured? ☐ Yes ☐ No

If No, how was the application taken?

☐ Phone ☐ Video Conferencing (FaceTime, Skype, Teams, Webex, Zoom, etc.) ☐ Mail ☐ Email

Is there an Application for Child Rider that should be processed with this application? ☐ Yes ☐ No

Are there additional applications or other related life applications that should be processed with this application? ☐ Yes ☐ No

If yes, name of proposed insured(s) on related application: _____

Before submitting the application, you must: (1) provide all parties the attached Consumer Protection Notice; (2) provide the Proposed Insured the Fair Credit Reporting Act/MIB Notice; (3) if attached, provide the Owner and Proposed Insured the Notice of Insurance Information Practices; and (4) if attached, provide the Owner the Secondary Addressee or Third Party Request Form, and if applicable, submit completed form with the application.

Guaranteed Issue Whole Life applications: By affixing my signature to the Agent's Certification and Signature section of the application I hereby affirm that: (1) I was personally present with the Proposed Insured or video conferencing with the Proposed Insured when the application was completed; (2) I personally verified the identity of the Proposed Insured; (3) the Proposed Insured is not confined to a hospital, hospice, nursing home, convalescent home, or does not require home health nursing care; (4) 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 24 months); and (5) I have no knowledge of intravenous drug abuse (IVDA) of the Proposed Insured.

Special Instructions you want us to know: _____

_____

MAIL POLICY TO: ☐ Owner ☐ Agent

Personal History Interview (PHI):

NOTE: A PHI will generally not be required with eApp cases.

UHL will order the PHI after you've completed the paper application with your client and submitted it to the Home Office. For paper applications, 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. **UHL WHOLE LIFE PRODUCTS USE THE "AGE LAST BIRTHDAY" METHOD FOR DETERMINING INSURANCE AGE OF THE PROPOSED INSURED.**
2. Print legibly in English.
3. Keep original app until policy is issued.
4. If faxing, keep fax confirmation message that fax was successful.
5. If the replacement question is answered "Yes," ensure that the applicable replacement form(s) has been completed and included (if required).
6. Cash should not be collected for the payment of premium(s), only client check or client obtained money order made payable to United Home Life Insurance Company.
7. Signature of spouse is required in community property states when a person other than the Owner's spouse is named as primary beneficiary with a Share % greater than 50. Community property states are Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.
8. Only one signature is required on the application for agent commission split requests. Provide all agent specific information in the second section on Page 1. Do NOT use the Special Instructions section.
9. Appointment regulations vary by state and some require appointment prior to taking an application. Check with the state or review your appointments on our agent portal to ensure compliance prior to taking an application. If you do not have access to our agent portal, contact us to confirm your contract is being processed. Promptly submit applications to ensure Just In Time Appointment processing of your first application in a non-pre-appoint state.

CONSUMER PROTECTION NOTICE

Effective: December 1, 2019

United Home Life Insurance Company and United Farm Family Life Insurance Company ("we," "us," and "our") are committed to protecting the information collected about our policy owners, insureds, applicants, beneficiaries, claimants, and other natural persons who visit our website or otherwise interact with us in connection with our insurance products and services ("you" and "your"). This notice describes how we may collect, use, and share information about you and how you may request access to or deletion of this information. WE WILL NOT DISCRIMINATE AGAINST YOU FOR EXERCISING ANY OF THE CONSUMER PROTECTION RIGHTS GRANTED TO YOU BY LAW OR IN THIS NOTICE.

COLLECTING YOUR PERSONAL INFORMATION

There are a variety of sources we use to collect information that identifies, relates to, describes, or could reasonably be linked to or associated with you or your household (collectively, "your personal information"). The categories and sources of your personal information we collect include:

- **Demographic Data.** We collect contact details and demographic information that you or your family members provide to us as part of the insurance application process, such as your name, address, telephone number, email address, Social Security number, birth date, physical characteristics, habits, income, driver's license number, passport number, occupation, employment history, gender, and marital status.
- **Payment Information.** When you apply for coverage, we collect billing information and other financial account information you voluntarily share with us, such as your bank account number, and credit or debit card number.
- **Health and Medical Records.** As part of our underwriting process, we obtain information about your health history, medical records, and prescription history from you, your health care providers, pharmacies, and insurance support organizations, such as information about your current medical impairments and insurability, historical medical or prescription information, and biometric information.
- **Credit History.** From consumer-reporting agencies, third party services providers, and public records, we may collect information about your credit history and credit worthiness.
- **Prior Transactions.** We may collect information from you, consumer credit reporting agencies, and insurance support organizations about your prior insurance transactions and experiences, such as products purchased, payment history, and life insurance cash value or loan balances.
- **Derived Data.** Our servers automatically collect some data when you access our website, such as your device name and type, IP address, version of your operating system, access times, browser information, and settings. Data may also be collected via tracking technologies to recognize you and your actions that are integral to our website.
- **Location Information.** When you access our website, we may collect your generic location data, such as city, latitude, longitude, and compass-related data. Various technologies are used to determine location, including IP address, GPS, Wi-Fi access points, and cell towers.

USING YOUR PERSONAL INFORMATION

We use your personal information for one or more of the following purposes:

- **Underwriting and Claims Activities.** Your personal information is used to underwrite your application for coverage and make eligibility, risk, rating, and policy issuance decisions. In the event of a claim, we use your personal information to administer the claim.
- **Customer Service and Policy Fulfillment.** Your personal information is used to verify your identity before responding to inquiries for coverage information and other products and services that may be of interest. Additionally, we must fulfill our responsibility for coverage and use your personal information to meet policy obligations.
- **Fraud Detection.** In the unlikely event of suspicious activity associated with you or your policy, your personal information may be used in our investigation and to help detect and prevent insurance fraud, data security breaches, and other unauthorized acts.
- **Data Analysis and De-Identification.** Except as otherwise prohibited by law, we may use your personal information to compile anonymous statistical data and to create data not linked or reasonably linkable to you or your household.
- **Other Permitted Activities.** We may use your personal information to conduct other legally permitted activities in connection with any coverage you have or have applied for with us as well as for the purpose of monitoring and analyzing usage of our website and insurance trends or as otherwise permitted by law.

SHARING YOUR PERSONAL INFORMATION

WE DO NOT SELL YOUR PERSONAL INFORMATION. We may share your personal information as follows:

- **With Service Providers.** We may share any or all of your personal information with third parties that provide services for or on our behalf in order to help us underwrite insurance, process transactions, administer claims, and run our operations. These third parties include, without limitation, independent insurance agents, consumer reporting agencies, insurance support organizations, other insurers, payment processors, data analytics services, email delivery vendors, and web hosting services.

- **With Health Care Providers.** Your personal information may be provided to health care providers to verify insurance coverage, inform you of medical history you may not be aware of, and to verify medical treatment or services.
- **To Transfer Risk.** As a risk management tool, we may transfer some of our insurance risk to reinsurers that may request information about our insureds in order to evaluate, allocate, or assume the risk.
- **With Governmental Authorities.** We will disclose your personal information to an insurance regulatory authority and any other governmental agency with jurisdiction over us to comply with audits and to respond to consumer complaints or any other lawful purpose as permitted or required by any applicable law, rule, or regulation.
- **To Respond to Legal Actions.** If we believe the release of your personal information is necessary to respond to a subpoena, other legal process, or a request for information, we will share your personal information with persons covered by evidentiary privilege as permitted or required by any applicable law, rule, or regulation.
- **To Protect Our Lawful Interests.** We will share your personal information with consumer credit reporting agencies, insurance support organizations, insurance regulatory authorities, law enforcement, and other governmental agencies as necessary to investigate or remedy potential violations of our policies, to prevent insurance fraud, to reduce credit risk, or to otherwise protect the rights, property, and safety of others.
- **With Affiliates and Subsidiaries.** We may share your personal information within our family of companies to provide customer service, account maintenance, or to tell you about products and services that may be of interest to you.
- **With Our Marketing Service Providers.** We may share contact and limited demographic information, such as age and gender, with third parties that perform marketing services for or on our behalf.
- **For Research Studies.** We may share some of your personal information with organizations that conduct actuarial or research studies; however, no individually identifiable medical information is disclosed.

ACCESSING YOUR PERSONAL INFORMATION

You may request access to your personal information by submitting a written request that we disclose to you the following:

- The categories of your personal information that we collected
- The categories of sources from which your personal information is collected
- The specific pieces of your personal information that we collected
- The business purpose for collecting your personal information
- The categories of your personal information that we disclosed for business purposes
- The categories of third parties with whom we shared your personal information

Upon receipt of a verifiable consumer request from you or a legally appointed individual authorized to act on your behalf (such as a power of attorney), we will promptly take steps to disclose and deliver the requested information to you either by mail or electronically in a user-friendly readable and transferable format. Your request must include sufficient details that allow us to properly understand, evaluate, and reply. If we are unable to verify your identity or authority to make the request on your behalf, we will not release your personal information or otherwise comply with the request.

DELETING YOUR PERSONAL INFORMATION

You may request that we delete any or all of your personal information that we collected. Upon receipt of a verifiable consumer request from you, we will take steps to delete your personal information from our records and direct any service providers to delete your personal information from their records or notify you that your request for deletion cannot be honored. We may deny your deletion request if retaining your personal information is necessary to: Complete the transaction, fulfill our obligations, or keep a record of the transaction for which we collected your personal information, such as providing life insurance coverage; reasonably anticipate your personal information will be required within the context of our ongoing or former business relationship with you; enable solely internal uses that are reasonably aligned with the expectations of reasonable insurance consumers; comply with legal obligations or any applicable law or regulation; detect security incidents, protect against insurance fraud or other illegal activity; or otherwise use your personal information for internal purposes only, in a lawful manner, that is compatible with the business context in which you provided the information.

METHODS FOR SUBMITTING REQUESTS

If you wish to request access to or deletion of your personal information, please contact us via either of the following designated methods:

Toll Free Telephone Number: 1-800-428-3001
Email Address: Life.ContactCenter@unitedhomelife.com

We reserve the right to update this notice at our discretion and at any time or for any reason. Any changes we make to this notice will apply to all information we have about you. When we make changes, we will post the revised notice in the Privacy Center of our website at www.unitedhomelife.com. This notice supplements our Privacy Notice (form #18-348 or #200-348) and our Notice of Insurance Information Practices (form #18-671 or #200-671) if you reside in AZ, CA, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR, or VA.

Application for Individual Life Insurance

United Home Life Insurance Company

225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

Notice: You are completing an application for life insurance. You have taken the step to protect against a catastrophic loss. 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. Please be aware of your answers as they may result in your beneficiaries not receiving the life insurance benefit.

SECTION 1 – Proposed Insured

Last Name	First Name	Middle Initial

Date of Birth (M-D-Y)	Place of Birth (State, Country if other than U.S.)	❑ Male ❑ Female

Marital Status	Height	Weight

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

Street Address (Physical street address, not a P.O. Box) **(Required)**

City **(Required)**	State **(Required)**	Zip Code **(Required)**

Mailing Address (if different from Street Address)

City	State	Zip Code

Phone Number	Email Address

Employer/Occupation/Duties/How Long There **(Required for Proposed Insureds under age 65)**

SECTION 2 – Ownership
(Is Proposed Insured also the Owner? If yes, skip this Section.)

Owner Name	Relationship to Proposed Insured	Marital Status

Social Security Number	Owner Email Address

Owner Street Address (Physical street address, not a P.O. Box)

City	State	Zip Code

Mailing Address (if different from Street Address)

City	State	Zip Code

Contingent Owner Name	Relationship to Proposed Insured	Social Security Number

SECTION 3 – Premium Payor
(Is Owner also the Premium Payor? If yes, skip this Section.)

Payor Name	Relationship to Proposed Insured

Social Security Number	Payor Email Address

Payor Street Address (Physical street address, not a P.O. Box)

City	State	Zip Code

Mailing Address (if different from Street Address)

City	State	Zip Code

SECTION 4 – Secondary Addressee (Third Party)
(Do you want to name an additional person to receive copies of past due notices? If no, skip this Section.)

Secondary Addressee Name

Secondary Addressee Street or Mailing Address

City	State	Zip Code

SECTION 5 – Beneficiary(ies)
Who do you want to protect?

Primary Beneficiary Name			Relationship
Age	Date of Birth (M-D-Y)	Social Security Number	Share %
Primary Beneficiary Name			Relationship
Age	Date of Birth (M-D-Y)	Social Security Number	Share %
Contingent Beneficiary Name			Relationship
Age	Date of Birth (M-D-Y)	Social Security Number	Share %

SECTION 6 – Plan of Insurance

Plan of Insurance ❑ Express Issue Premier ❑ Express Issue Deluxe
❑ Express Issue Whole Life (Graded Death Benefit)
❑ Guaranteed Issue Whole Life (Graded Death Benefit Endowment)

Face Amount: $_____

❑ Check here if you are willing to accept any product listed in this section for which the Proposed Insured qualifies based on this application. The insurance for which the Proposed Insured qualifies may have a graded death benefit in the first 2 policy 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 the Proposed Insured qualifies.

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 Guaranteed Issue Whole Life or Express Issue Whole Life) $_____

SECTION 7 – Payment Information

Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly EFT* Modal Premium Amount $_____

$_____paid with application.

***If selected, complete EFT (Electronic Fund Transfer) authorization form.**

SECTION 8 – Other Insurance

Do you have any existing life insurance or annuity contracts? ❑ Yes ❑ No

If "Yes," please complete and sign any necessary replacement forms.

Is the insurance applied for intended to replace or change any life insurance or annuity contract in force? ❑ Yes ❑ No

If "Yes," please complete and sign any necessary replacement forms.

SECTION 9 – Nicotine Use

Has the Proposed Insured used nicotine replacement, smoking or tobacco products in any form including, but not limited to: nicotine gum, patch or pills, cigarettes, cigars, chew, pipe, e-cigarettes, or vape in the past 12 months? ❑ Yes ❑ No

SECTION 10 – Physician Information
(Must have been seen within the past three (3) years.)

Name of Family Physician **(Required)**	Family Physician Phone Number **(Required)**

Family Physician Address **(Required)**

SECTION 11 – Medical & Personal History Questions
(For the purposes of these questions, "you" or "your" mean the Proposed Insured.)

If the plan selected in Section 6 is the Guaranteed Issue Whole Life the Proposed Insured should not answer the questions below.

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

If any question in Part A is answered "Yes", the Proposed Insured is 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 by a member of the medical profession that you need an organ transplant; or have you been diagnosed by a member of the medical profession as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within 24 months.)	❑ Yes ❑ 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?	❑ Yes ❑ No
C. Have you ever been diagnosed or treated by a member of the medical profession for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency disease; or have you tested positive for the human immunodeficiency virus (HIV)?	❑ Yes ❑ No
D. Have you ever been diagnosed, treated, or been given medical advice by a member of the medical profession for Alzheimer's disease, dementia, mental incapacity, or cognitive impairment?	❑ Yes ❑ No
E. **In the past 12 months:**	
1. Other than for minor conditions, have you been hospitalized two or more times?	❑ Yes ❑ No
2. Have you been treated for or diagnosed by a member of the medical profession with any cancer (other than basal cell skin cancer), heart attack, congestive heart failure, cardiomyopathy, stroke, or had heart surgery (including angioplasty)?	❑ Yes ❑ No
3. Have you used any illegal drugs or been treated for or advised to have treatment for drug abuse by a member of the medical profession?	❑ Yes ❑ No

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

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

A. **In the past 2 years:**	
1. Have you been diagnosed, treated, or advised to seek treatment by a member of the medical profession for, or consulted with a member of the medical profession regarding:	
a. Diabetes with complications of retinopathy (eye), nephropathy (kidney), or neuropathy (nerve damage or numbness)?	❑ Yes ❑ No
b. Any form of cancer (other than basal cell skin cancer) or brain tumor?	❑ Yes ❑ No
c. Coronary artery disease (CAD), heart attack, heart valve disease, cardiomyopathy, congestive heart failure, aneurysm, stroke, irregular heart rhythm, peripheral artery disease (PAD / PVD), or had surgery for any heart disorders (including angioplasty) or circulatory disorders (excluding varicose veins)?	❑ Yes ❑ No
d. Sickle cell anemia, kidney disease (including renal insufficiency, renal disease, or any condition that required dialysis), or liver disease (including cirrhosis, hepatitis, including B or C)?	❑ Yes ❑ No
e. Lung disease or respiratory disease, including chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, or any other type of chronic lung disease or ongoing respiratory disorder (excluding controlled, mild asthma not requiring any hospitalization in the past 2 years)?	❑ Yes ❑ No
f. ALS (Lou Gehrig's disease), Parkinson's disease, muscular dystrophy, multiple sclerosis, Huntington's disease, or seizure disorder with seizures within the past 2 years?	❑ Yes ❑ No
2. Have you been advised by a member of the medical profession to have any tests (excluding an HIV test), surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test (excluding an HIV test) results pending?	❑ Yes ❑ No
3. Have you been treated, been advised to limit or discontinue use, or been advised to have treatment by a member of the medical profession for alcohol or drug abuse, or abused or misused prescription drugs?	❑ Yes ❑ No
B. **In the past 7 years,** have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	❑ Yes ❑ No

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

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

A. **In the past 12 months**, have you been declined for Life Insurance?	❑ Yes ❑ No
B. **In the past 2 years:**	
1. Have you been diagnosed, treated, or advised to seek treatment by a member of the medical profession for, or consulted with a member of the medical profession regarding:	
a. Schizophrenia, bipolar disorder, or suicide attempt?	❑ Yes ❑ No
b. Major depression for which you have been hospitalized within the past 12 months?	❑ Yes ❑ No
c. Diabetes requiring insulin treatment?	❑ Yes ❑ No
d. Systemic lupus erythematosus (SLE)?	❑ Yes ❑ No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	❑ Yes ❑ No
C. 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?	❑ Yes ❑ No

SECTION 12 – 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 on this application are true and complete to the best of my knowledge and belief whether written by my own hand or not. The statements and answers in this application are the basis for any policy issued by United Home Life Insurance Company ("UHL"). I understand and agree that no information or knowledge obtained by any agent, medical examiner, or any other person in connection with this application shall be construed as having been made known to or binding upon UHL unless such information is in writing and made a part of this application. I will notify UHL of any changes in the statements or answers given in this application between the time of application and delivery of the policy. I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium due is paid while the Proposed Insured is living; or the date of my written acceptance of the policy if issued other than applied for and the premium due is paid while the Proposed Insured is living.

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

I hereby certify under penalties of perjury, that the tax identification number provided is true, correct, and complete.

SECTION 13 – Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, or other medical or medically related facility, electronic health record provider, medical information retrieval service, insurance company, MIB, Inc. ("MIB"), 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, persons or entities performing business, professional, or insurance functions for UHL or as may otherwise be legally allowed. I further authorize UHL or its reinsurer(s) to make a brief report of my personal health information to MIB. 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. Prior to testing, I must be provided and sign a separate notice and consent form if required by the state where the policy is delivered or issued for delivery.

A photographic copy of this authorization shall be as valid as the original. This authorization may be used for any legitimate insurance purpose for up to 24 months from the date of my signature below. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits, or for UHL to determine its obligations under the policy issued in connection with the application. I have the right to revoke this authorization at any time by submitting a written request to UHL's Home Office. The revocation is limited to the extent that action has been taken by UHL in reliance on this authorization or the law allows UHL to contest the issuance of the policy. Failure to sign the authorization or revoking the authorization may result in the inability of UHL to process the application. I or my authorized representative have a right to receive a copy of this authorization.

SECTION 14 – 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 ("UHL") and its agents, employees, and representatives. UHL may 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. 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 UHL 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 UHL.

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. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. 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 UHL 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, UHL may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I or my authorized representative have a right to receive a copy of this authorization.

SECTION 15 – Disclosure Acknowledgment

❑ **I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount. (This rider is not available with the Guaranteed Issue Whole Life or Express Issue Whole Life plans.)**

SECTION 16 – Signatures

Signature applies to Sections 1 through 15. Review before signing.

Dated at _____, this _____ day of _____, _____.

Signature of Proposed Insured or personal representative (Must be signature of Proposed Insured for Guaranteed Issue Whole Life)

Description of personal representative's authority to act

Signature of Owner (If other than Proposed Insured)

Signature of Spouse (Required in community property states when a person other than the Owner's spouse is named as Primary Beneficiary with a Share % greater than 50. Community property states are Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin.)

SECTION 17 – Agent's Certification and Signature

To the best of my knowledge and belief the applicant does ❑ does not ❑ have any existing life insurance or annuity contracts.

To the best of my knowledge and belief the insurance applied for is ❑ is not ❑ intended to replace or change any existing life insurance or annuity contract in force.

❑ I certify that I have provided the Owner a copy of the Terminal Illness Accelerated Benefit Disclosure Statement and a numerical illustration.

X_____ **X**_____

Printed Agent Name | Agent's Signature

Agent Code_____ Agent's E-Mail _____

Agent: Phone #_____ Fax#_____ License Identification Number (_____) _____

State

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**

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. Do not pay with cash.

I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium due is paid while the Proposed Insured is living; or the date of my written acceptance of the policy if issued other than applied for and the premium due is paid while the Proposed Insured is living.

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 (except as may be related to sexual orientation) and is obtained through personal interviews with friends, neighbors, and associates of the consumer. You may request to be interviewed in connection with the preparation of any such report. 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 ("UHL") or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc. ("MIB"), a not-for-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.

UHL 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.

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.

TERMINAL ILLNESS ACCELERATED BENEFIT DISCLOSURE STATEMENT

(This rider is not available with the Guaranteed Issue Whole Life or Express Issue Whole Life plans.)

Benefits paid under this rider may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit. Additionally, payment of an accelerated death benefit may also adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Description of Benefits - This rider provides you with the right to access the Death Benefit (discounted at interest for one year)* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

Effect on the Policy - When the accelerated benefit is paid, the policy terminates.

Example - This example is for illustration only, uses a $50,000 policy and an interest rate of 7%.* **The amounts shown are not based on your specific policy.**

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Death Benefit	$50,000.00
Less 7%	3,271.03
Accelerated Benefit	**$ 46,728.97**

*The interest rate used to discount this benefit is defined in your Terminal Illness Accelerated Benefit Rider.

ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION FORM

225 South East Street • P.O. Box 7192 • Indianapolis, IN 46207-7192
Phone: 1-800-428-3001
Fax: New Policy Application: 317-692-7711
Fax: Existing In Force Policy: 317-692-8402

Section 1 – Financial Institution Information - Always Complete This Section		
Financial Institution Name		
Account Number	Routing Number	Type of Account (check one) ☐ Checking ☐ Savings
Account Holder Printed Name		Relationship if other than Owner
Account Holder Address		

Section 2 – Complete This Section For A New Policy Application

Name of Proposed Insured

The initial modal premium must be quoted in the payment information section of the application. We do not accept debit or credit cards at the time of application. **I understand that the policy will not be effective until the later of: the date it is issued by the Company as applied for and the premium paid; or the date of the Owner's written acceptance of the policy if issued other than applied for and the premium paid.**

1. Draft my account for the **first** premium (check one):

   ☐ Immediately upon receipt of the application in the Home Office.
   ☐ On the date of issue (policy date).
   ☐ On _____ (month & day). Choose any day between the 1st and the 28th.
   ☐ On the [☐ 2nd ☐ 3rd ☐ 4th] (check one) Wednesday of _____ (month).
   ☐ Do NOT draft my account for the first premium. The first premium is attached, is being mailed, or will be collected on delivery. The Company name should appear as the Payee. Do not leave the Payee field blank, do not make payable to the agent, and do not postdate. Do not pay with cash.

2. Unless indicated below all **subsequent** premiums will be drafted on the same day each month as the **first** premium.

   Draft subsequent premiums on the ___ (1st – 28th) day of each month.

Section 3 – Complete This Section For An Existing In Force Policy

Name of Insured	Policy Number

Requested draft day ___(1st – 28th) **OR** the [☐ 2nd ☐ 3rd ☐ 4th] (check one) Wednesday of each month. If day is not specified, the draft day will be based upon the date of issue (policy date).

Billing Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

If the billing mode is not specified, the billing mode will default to monthly.

Section 4 – Authorization – Always Complete This Section

I request and authorize my financial institution to honor deductions from my account that are initiated by United Home Life Insurance Company or United Farm Family Life Insurance Company (the "Company") for the current policy premium, including policy renewals and/or changes. By signing below, I authorize the Company to receive information from the financial institution named so my account number and routing number may be verified.

I understand and agree that the Company is not responsible for any charges from my financial institution. A dishonored deduction may be resubmitted. A dishonored deduction may cause the policy to lapse for non-payment of premium. I may terminate this EFT Authorization by giving 15 days prior written notice to the Company. The Company may terminate this EFT Authorization agreement upon any deduction returned as dishonored, or upon 15 days prior written notice.

Account Holder Signature _____ Date _____

HOME OFFICE USE ONLY

Call Representative/ACID _____ Date _____ Time _____ Call ID# _____

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

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions.

Do you have any existing insurance policies or annuities? _____YES _____NO

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _____YES _____NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____YES _____NO

   If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (including the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	Insurer Name	Contract Or Policy #	Insured Or Annuitant	Replaced (R) Or Financing (F)
1.				
2.				
3.				

   Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because_____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant’s Signature and Printed Name Date

_____ _____
Producer’s Signature and Printed Name Date

I do not want this notice read aloud to me. __(Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

UNITED HOME LIFE INSURANCE COMPANY
P.O. Box 7192
Indianapolis, IN 46207-7192
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You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
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OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

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

Producer Replacement Acknowledgement Form

(Complete this form only if a replacement is involved)

_____
Applicant's Name (printed)

I only used Company approved, either preprinted or electronically generated, sales materials in connection with the solicitation of this application.

I left a copy of any preprinted material(s) with the applicant. I either left a copy of any electronically presented material with the applicant or I will deliver a copy to the policy owner no later than when the policy is delivered.

_____
Producer's Signature Date

_____
Producer's Name (printed)