



# NEW BUSINESS MEMO

## WHOLE LIFE

Telephone: 800-428-3001

**Regular Mail:**

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

**Overnight Mail:**

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

|  |  |
|--|--|
| <b>AX Number:</b> 317-692-7711   | _____ # pages including cover  |
| Agt Name: _____  | Agt # _____  |
| Agt Phone: _____   | Agt Fax: _____   |
| Agt Email Address: _____@_____.  |  |
| Did you personally see all persons proposed for insurance, read each question to the proposed insured and record their answers? <input type="checkbox"/> Yes <input type="checkbox"/> No           |  |
| If No, how was the application taken? Solicited by: <input type="checkbox"/> mail <input type="checkbox"/> telephone <input type="checkbox"/> internet <input type="checkbox"/> fax or other _____ |  |
| We conduct random Personal History Interviews. If we conduct a PHI with your client, what is the best time to reach the client?  |  |
| Home phone (____) _____  | available days? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Business phone (____) _____  | available days? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If a language other than English is required, please specify below.  |  |
| Special Instructions you want us to know: _____  |  |
| _____  |  |
| _____  |  |
| _____  |  |

### Application Completion "Tips"

1. Make sure to use the app with the correct state variations
2. If Child Rider is requested, submit application 200-359
3. If the first premium is going to be drafted from the client's bank account, *provide a copy of a voided check!* Otherwise, the case will be unnecessarily delayed
4. Print legibly in English
5. Keep original app until policy is issued
6. Keep fax confirmation message that fax was successful

**MAIL POLICY TO:**  Applicant  Agent

# Whole Life Insurance Application

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

|                |        |            |                        |                |  |                     |  |
|----------------|--------|------------|------------------------|----------------|--|---------------------|--|
| 1. Last Name   |        | First Name |                        | Middle Initial | Date of Birth (M-D-Y)  | State of Birth      | <input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Marital Status | Height | Weight     | Social Security Number |                | U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, give immigration status/type of visa:</i> |                     |  |
| Street Address |        | City       |                        | State          | Zip Code   | Phone Number<br>( ) |  |

2. Employer/Occupation/Duties/How Long There

|  |      |              |  |                        |          |          |
|--|------|--------------|--|------------------------|----------|----------|
| 3.a. Primary Beneficiary Name                |      | Relationship |  | Age                    |          |          |
| 3.b. Contingent Beneficiary Name             |      | Relationship |  | Age                    |          |          |
| 4.a. Owner Name                              |      | Relationship |  | Social Security Number |          |          |
| Owner Street Address                         |      | City         |  | State                  | Zip Code |          |
| 4.b. Contingent Owner Name                   |      | Relationship |  | Social Security Number |          |          |
| 5. Billing Street Address                    |      | City         |  | State                  | Zip Code |          |
| Secondary Addressee<br>(For Past Due Notice) | Name | Street       |  | City                   | State    | Zip Code |

|   |  |  |  |
|---|--|--|--|
| 6.a. Plan of Insurance <input type="checkbox"/> Express Issue Deluxe <input type="checkbox"/> Express Issue Premier |  | 6.b. Insurance Amount: \$ _____  |  |
| 6.c. <input type="checkbox"/> Accidental Death Benefit \$ _____   |  | 6.d. Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Qtrly. <input type="checkbox"/> PAC<br>Modal Premium Amount \$ _____ |  |

7. Will this insurance replace or change any other insurance policies or annuities?  Yes  No *If "Yes," please provide the complete details of the insurance to be replaced, including amount, company and plan of insurance in Number 10., and complete any necessary replacement forms.*

8. Has the proposed insured used nicotine in any form in the past 12 months?  Yes  No

9. Name and Address of Family Physician (Required)

## SECTION I - EXPRESS ISSUE DELUXE - COMPLETE SECTION I ONLY

|   |  |
|---|--|
| A. Do you currently receive kidney dialysis or require oxygen use or have you been diagnosed as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. Do you require assistance to eat, bathe, dress or take your own medication or are you currently confined to a hospital, nursing home, mental facility or Hospice or have you been hospitalized two or more times in the past twelve months?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immune disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. In the past 5 years, have you been diagnosed or treated for, or are you currently under treatment for: Alzheimer's Disease, any form of Cancer (other than Basal Cell skin cancer), Heart or Circulatory Disorder (except controlled hypertension), Sickle Cell Anemia, Stroke, Kidney Disease (including dialysis), Liver Disease, any Lung Disease (except mild asthma not requiring daily medication), ALS (Lou Gehrigs Disease) or other neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years) or surgery for any Heart or Circulatory Disorder (except varicose veins) or transplant of any organ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| E. Are you currently disabled or been disabled in the last six months, or at any time during the last six months been unable to mentally or physically complete 30 hours per week of active employment or have you been declined or postponed for Life or Health Insurance in the past two years?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| F. In the past 10 years have you been convicted of a felony; or in the past 5 years have you been treated for, been advised to have treatment for or excessively used alcohol or any drugs of abuse?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Any questions answered "Yes" in this section will disqualify the applicant for the Express Issue Deluxe Policy.

Details to any questions, add to the next page.



PLEASE DETACH AND GIVE TO APPLICANT

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

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

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

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

**RECEIPT**

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

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

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

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

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

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

**FAIR CREDIT REPORTING ACT/MEDICAL INFORMATION BUREAU NOTICE**

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

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MEDICAL INFORMATION BUREAU, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



## Authorization for Release of Medical Information

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

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

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

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

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

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

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

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

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

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

\_\_\_\_\_  
Date

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