



# 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

FAX Number:	317-692-7711	_____	# pages including cover
Agt Name:	_____	Agt #	_____
Agt Phone:	_____	Agt Fax:	_____
Agt Email Address:	_____@_____._____		
How do you prefer to be notified if we should need any underwriting requirements? <input type="checkbox"/> E-Mail <input type="checkbox"/> Fax <input type="checkbox"/> US Mail Street _____ City _____ State _____ Zip Code _____			
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 Cell 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)	<input type="checkbox"/> Male
						<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 ( )

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 (For Past Due Notice)	Name	Street	City	State Zip Code

6.a. Plan of Insurance <input type="checkbox"/> Graded Death Benefit Whole Life <input type="checkbox"/> Whole Life Deluxe <input type="checkbox"/> Whole Life Premier	6.b. Insurance Amount: \$
6.c. <input type="checkbox"/> Accidental Death Benefit (not available with Graded Death Benefit WL)	6.d. Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Qtrly. <input type="checkbox"/> PAC
\$	Modal Premium Amount \$

7. Do you have any existing life 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 – GRADED DEATH BENEFIT WHOLE LIFE – 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

Any question answered "Yes" in this section will disqualify the applicant for the Express Issue Whole Life Policy.

## SECTION II – WHOLE LIFE DELUXE – COMPLETE SECTIONS I & II ONLY

A. 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
B. 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
C. 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 question answered "Yes" in this section will disqualify the applicant for the Express Issue Deluxe Policy.

Details to any questions, add to the next page.



Check or money order must accompany. All premium checks must be made payable to United Home Life Insurance Company. Do not make check or money order payable to the insurance producer or leave the Payee blank. Include copy of voided check for bank draft.

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

Draft my account for the first premium (initial premium may be drafted upon receipt of this application)

Monthly Draft Date for Subsequent Drafts: \_\_\_\_\_

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

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

TO: \_\_\_\_\_ Bank \_\_\_\_\_ Bank Address \_\_\_\_\_

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry.

I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account No. \_\_\_\_\_ Date \_\_\_\_\_ Bank signature of Premium Payor \_\_\_\_\_

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 insurance producer 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

Insurance Producer 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