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

IMPORTANT: Your client is not automatically disqualified if an underwriting question is answered "yes"; it depends on the severity of the condition. Information should be provided in Section 10 for special consideration.

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?
☐ E-Mail ☐ Fax ☐ 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?
☐ Yes ☐ No

If No, how was the application taken? Solicited by: ☐ Mail ☐ Telephone ☐ Internet
☐ Fax or Other ___________________________________

PHI'S: We require Personal History Interviews on all Applicants applying for Total Protection Series III Deluxe and Premier plans, regardless of face amount. We also require PHIs on all applicants applying for more than $25,000 of coverage on the graded benefit Express Issue Whole Life Plan. As the agent, you can initiate the interview from the client's home by calling 877-801-9496 (M-F, 8:30 a.m.-8:30 p.m. EST). Tell the operator this interview is for United Home Life Insurance Company and the Total Protection Series EIWL Deluxe or Premier and hand the phone to your client. A traditional PHI will be ordered by the Home Office if a Point of Sale PHI is not completed by you. Detailed explanation is on our website at www.unitedhomelife.com.

Did you complete a POS PHI with your client? ☐ Yes ☐ No

If we have to conduct a PHI with your client, what is the best time to reach the 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 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 pre-printed 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

GENERAL UNDERWRITING GUIDE

For Total Protection Series Final Expense Products

Please note that certain conditions may result in a "Yes" answer on the application, but can still be considered.

Please provide full details in Section 10 for any "Yes" answers and we will consider the case for issue.

My client has a history of:	Not Eligible	EIWL (Table 16 max)	Deluxe (Table 8 max)	Premier (Table 4 max)
Cancer (other than Basal Cell skin cancer):				
Diagnosed within past 12 months	✓			
Over 12 months ago; no or minor treatment in past 12 months and in remission		✓		
Over 12 months ago; major treatment in past 12 months	✓			
Over 5 years ago; no or minor treatment in past 5 years and in remission		✓	✓	*IC
Over 5 years ago; major treatment in past 5 years		*IC	*IC	*IC
Examples of minor treatment - preventive or risk lowering medications ***Examples of major treatment*** - chemotherapy, radiation therapy, surgery **Note: Routine checkups are not considered treatment**				
Heart attack, heart surgery or stroke:				
Diagnosed or surgery within past 12 months	✓			
Over 12 months ago; no or minor treatment in past 12 months		✓		
Over 12 months ago; major treatment in past 12 months		*IC		
Over 5 years ago; no or minor treatment in past 5 years		✓	✓	✓
Over 5 years ago; major treatment in past 5 years		*IC	*IC	
Examples of minor treatment - preventive or risk lowering medications, including for high blood pressure or high cholesterol, and condition stable ***Examples of major treatment*** - medication (excluding maintenance medications) to treat either ongoing symptoms or progression of the condition, surgery **Note: Routine checkups are not considered treatment**				
Other Conditions:				
Any oxygen use	✓			
Chronic Obstructive Pulmonary Disease/Emphysema, not requiring oxygen		✓		
Diabetes requiring insulin treatment		✓	✓	
Diabetes treated with diet or oral hypoglycemic medications		✓	✓	✓
Hospitalizations: 2 or more within the past 12 months for minor medical conditions		✓	✓	✓
Hospitalizations: 2 or more within the past 12 months for major medical conditions		*IC		
Currently disabled due to a medical condition		✓		
Currently disabled due to a minor or temporary medical condition		✓	*IC	*IC

*** IC=Individual Consideration. In order to be considered, please answer the medical question "Yes" and provide full details in Section 10.**

Contact the Home Office at (800) 428-3001 with questions about specific conditions.

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	❑ Male ❑ Female

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

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 ❑ Express Issue Whole Life **6.b.** Face Amount: $________________________

6.c. If the Face Amount shown above is $10,000 or greater and the product applied for 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.

6.d. Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Qtrly. ❑ PAC

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)	Family Physician Telephone Number (Required) ( ) -

EXPRESS ISSUE WHOLE LIFE

	Question	
A.	Do you currently receive kidney dialysis or require oxygen use or have you received or been told that you need an organ transplant 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.)	❑ Yes ❑ No
B.	Are you currently not able to feed, bathe, dress or take your own medication on a daily basis or are you currently confined to a hospital, nursing home, mental facility, hospice or require home health care?	❑ Yes ❑ No
C.	Has the applicant ever been diagnosed as having or been treated for AIDS or ARC by a licensed medical physician?	❑ Yes ❑ No
D.	In the past twelve (12) months, have you been hospitalized two or more times, been diagnosed or treated for cancer (including melanoma and leukemia), heart attack, stroke, or had heart surgery or have you used, been treated for or advised to have treatment for any drugs of abuse?	❑ Yes ❑ No

10. Details of "Yes" answers to any Questions:

Dates	Name and Address of Physician	Diagnosis	Treatment

I hereby apply for the insurance indicated above and I am submitting the first premium. I certify that the answers on this application are true to the best of my knowledge and belief. I understand that my policy will be effective on the date it is issued by the company.

I declare that I have read and received a copy of the Fair Credit Reporting Act/Medical Information Bureau Notice.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases and alcohol or drug abuse treatment.

THIS AUTHORIZATION EXCLUDES the release of any information relating to previously administered **HIV TESTS** including tests for HIV Antibodies, T-Cell Counts, AIDS or ARC by the applicant's family physician, regular physician, attending physician, health care professional, hospital, clinic, medical facility, the Veteran's Administration, the Medical Information Bureau, Inc (MIB), employer, insurance company, reinsurer, consumer reporting agency, or any other person or entity that may be possessed of such information. **IN ADDITION**, the applicant is **NOT AUTHORIZING** the Insurance Company to forward the results of any new HIV related tests, requested by the Company in connection with this application, to any outside non-affiliated company nor to any person or entity not under direct contract with the Company to perform underwriting services in connection with this application.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be a crime, which only a court of competent jurisdiction can determine.

$______________________ paid with application.

Dated ____ , this _____________________ day of _____________________________ , ___________

City State Month Year

X ____ X ____

Signature of Owner (if other than Proposed Insured) Signature of Proposed Insured

To the best of my knowledge and belief the insurance applied for herein is ☐ is not ☐ intended to replace or change any existing life insurance or annuity coverage.

X ____ X ____

Printed Agent Name Agent's Signature

Agent Code _______________________________ Agent's E-Mail ____

Agent: Phone # _____________________________ Fax# _______________________ License Identification Number (____)________________________

State

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 agent 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

Please select ONLY one option, complete bank information and sign authorization below.

- ☐ Draft my account for the first premium (initial premium may be drafted upon receipt of this application). Please draft subsequent premiums on the _______ day of each month.
- ☐ Draft my account for the first premium on: ____________________ (*Month, Day*). All subsequent drafts will occur on this same day each month.
- ☐ Do NOT draft my account for the first premium. The initial premium is attached, is being mailed or will be collected on delivery. Please draft subsequent premiums on the ______ day of each month.

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 agent 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, 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 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 MIB, Inc., formerly known as 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 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 (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. Information for consumers about MIB may be obtained on its website at www.mib.com.

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