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?
☐ 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 ______________________

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? ☐ 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 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

200-492 1-06 (NV)

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 Deluxe ❑ Express Issue Premier | **6.b.** Insurance Amount: $

6.c. ❑ Accidental Death Benefit $ | **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)

SECTION I - EXPRESS ISSUE DELUXE – COMPLETE SECTION I ONLY

Question	Answer
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.)	❑ Yes ❑ 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?	❑ Yes ❑ 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?	❑ Yes ❑ 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?	❑ Yes ❑ 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?	❑ Yes ❑ 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?	❑ Yes ❑ 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.

SECTION II - EXPRESS ISSUE PREMIER – COMPLETE SECTIONS I & II

A. In the past 5 years, have you been diagnosed or treated for, or are you currently under treatment for: Schizophrenia, Bipolar Disorder, Diabetes requiring insulin treatment, SLE (Systemic Lupus Erythematosus)?	☐ Yes ☐ No
B. In the past 5 years, have you been convicted of operating a vehicle while intoxicated, or had your drivers license suspended or revoked?	☐ Yes ☐ No
C. Do you now participate in, or do you have plans to participate in any hazardous sport or aviation?	☐ Yes ☐ No

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

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 are true and accurate whether written by my own hand or not. I understand that my policy will not be effective until 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, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

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 guilty of insurance fraud, which is a crime.

$__________________ 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

☐ 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 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 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 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

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

IMPORTANT NOTICE REGARDING THE REPLACEMENT OF YOUR POLICY OF LIFE INSURANCE

You have been offered a policy to replace all or part of your existing policy of life insurance.

Before you replace your existing policy you should consider whether you could suffer a **FINANCIAL LOSS** under the new policy because of your **AGE** or the condition of your **HEALTH**. You should also consider whether you will pay more for premiums because of your age or health.

You **WILL** incur additional costs to acquire the new policy, including the payment of commissions to the agent advocating the replacement of your existing policy.

To make an informed decision about the replacement of your policy, you should discuss the provisions of your existing policy with your agent or the company which issued it to determine whether your policy can be changed to meet your present needs.

Your new policy provides 10 days for you to decide whether you wish to keep it.

The agent who is offering to replace your existing policy is required to obtain your signature on this notice. Also, he will be notifying your existing insurance company that you are considering the replacement of your policy.

I have read this notice and received a copy of it for my records.

________________ ________________________
Date Signature of Applicant

________________ ________________________
Date Signature of Agent

APPLICATION
for
CHILD RIDER

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

1-800-428-3001

United Home Life Insurance Company

Child Rider Application

Application is hereby made for Child Rider to be provided by supplementary provision or agreement attached to and made part of

Any policy to be issued on application dated____________________ } ____________________

Policy No. ____________________ } on the life of (hereinafter referred to as Insured)

1. Full name of children of Insured, including legally adopted children and stepchildren, who are under age 19	Relationship to Insured	Date of Birth*	Place of Birth (State or Country)	Ht.	Wt.

***PLEASE NOTE: No coverage is afforded infants under 30 days.**

2. Child Rider Amount ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 *Total amount of Child Rider coverages cannot exceed $20,000*

	YES	**NO**
3. In the past 5 years has any child named in Question 1 had: Any consultation or treatment by any physician or practitioner; examination in a clinic, hospital, dispensary, or sanitarium; any disease, ailment, injury or complaint which caused loss of time from school or work; any surgical operation, x-ray, electrocardiogram or other special tests, or been told there is a need for them?	☐	☐
4. In the past 10 years has any child named in answer to Question 1 had any deformity, impairment, abnormality or ailment of eyes, ears, arms, legs, brain, nervous system, heart, blood pressure, circulation, chest, lungs, digestion, kidneys, bladder or any other part of body, or been treated for a mental or nervous disorder?	☐	☐
5. Has any child named in answer to Question 1 been declined, postponed, limited, or had a policy issued other than as applied for on any life or health insurance or reinstatement thereof?	☐	☐
6. Is the insurance applied for intended to replace any insurance in this or any other company?	☐	☐

7. Give full details to questions requiring additional explanation.

Insured's Supplementary Statements and Certificate of Health

(Complete only if this is an addition to an existing policy)

1. Exact Height-Weight_______ Ft._____ In._______ Lbs. Has weight changed more than 10 lbs in past year? If yes, amount of increase_________ decrease_________	☐	☐
2. Since the date of the original application has the Insured had: Any consultation or treatment by any physician or practitioner; examination in a clinic, hospital, dispensary, or sanitarium; any surgical operation, x-ray, electrocardiogram, or other tests, or been told there is a need for them?	☐	☐

3. Name of physician Insured last consulted: ____________________

Address ____________________

Why consulted ____________________

Give name and address of family physician if different from above ____________________

4. Has Insured ever: Been exempted, or discharged as unfit, from military service; applied for or received any kind of disability compensation; or had an application for life or health insurance declined, postponed, limited, or issued other than as applied for?	☐	☐

5. Give full details to questions requiring additional explanation.

I hereby apply for the insurance indicated above and I am submitting the first premium. The statements 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, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

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 is guilty of insurance fraud, which is a crime.

$ ____________ 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 E-mail ____________________

Agent: Phone # ______________ Fax# ______________ License Identification Number ( ) ______________
State

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

*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.

PLEASE DETACH AND GIVE TO APPLICANT

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 Bureau company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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.

UNITED
HOME
LIFE™
Insurance
Company