



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: _____@_____.	
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 <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
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5. Billing Street Address	City	State	Zip Code
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Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code
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6.a. Plan of Insurance <input type="checkbox"/> Express Issue Whole Life <input type="checkbox"/> Express Issue Deluxe <input type="checkbox"/> Express Issue Premier	6.b. Insurance Amount: \$
6.c. <input type="checkbox"/> Accidental Death Benefit (not available with Express Issue 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. 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 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 - EXPRESS ISSUE 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, 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 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:
 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.

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?



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.

Are all children applying for coverage U.S. Citizens? Yes No *If no, give immigration status/type of visa:*

***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*
- | 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? | YES | NO |
|---|--------------------------|--------------------------|
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is the insurance applied for intended to replace any insurance in this or any other company? | <input type="checkbox"/> | <input type="checkbox"/> |
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 _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Give full details to questions requiring additional explanation. | | |

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 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

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*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.*

200-359 3-02 (RI)

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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.

200-359 3-02 (RI)



Simplified Products - Faster Results