



# ILLINOIS - APPLICATION FOR CHILDREN'S WHOLE LIFE INSURANCE

Please mail application and appropriate forms to:

United of Omaha Life Insurance Company, Attn: Individual Life Underwriting, 9330 State Hwy 133, Blair, NE 68008

## APPLICATION SUBMISSION GUIDELINES

- Attach a cover letter or additional information as needed.
- Leave all applicable forms and Life Insurance Buyer's Guide with the Proposed Insured.
- Please make sure all questions are answered and signatures completed.
- All changes should be initialed by the Owner/Applicant.
- If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

## IMPORTANT FORMS

- Replacement Notice – if applicable, the client must sign and retain a copy for their records
- Payment Authorization – Complete this form if applicable



# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY  
3300 Mutual of Omaha Plaza, Omaha, NE 68175



## APPLICATION FOR CHILDREN'S WHOLE LIFE INSURANCE

### SECTION A OWNER/APPLICANT

|   |                     |   |
|---|---------------------|---|
| Owner/Applicant Name (First Name, Initial, Last Name) | Social Security No. | <input type="checkbox"/> Male <input type="checkbox"/> Female |
|---|---------------------|---|

|   |                                 |
|---|---------------------------------|
| Home Address (Street, City, State, ZIP) | Date of Birth (Month, Day Year) |
|---|---------------------------------|

|              |                |
|--------------|----------------|
| Phone Number | E-mail Address |
|--------------|----------------|

Are you a legal permanent resident of the United States?.....  Yes  No

### SECTION B BENEFICIARY

|                     |               |                                  |               |
|---------------------|---------------|----------------------------------|---------------|
| Primary Beneficiary | % of Proceeds | Relationship to Proposed Insured | Date of Birth |
|---------------------|---------------|----------------------------------|---------------|

|                        |               |                                  |               |
|------------------------|---------------|----------------------------------|---------------|
| Contingent Beneficiary | % of Proceeds | Relationship to Proposed Insured | Date of Birth |
|------------------------|---------------|----------------------------------|---------------|

If more space is needed, attach a sheet for additional details.

### SECTION C SECONDARY ADDRESSEE (OPTIONAL) - THIS PERSON WILL RECEIVE COPIES OF OVERDUE PREMIUM AND LAPSE NOTICES.

|                                       |              |
|---------------------------------------|--------------|
| Name (First Name, Initial, Last Name) | Phone Number |
|---------------------------------------|--------------|

|                                    |
|------------------------------------|
| Address (Street, City, State, ZIP) |
|------------------------------------|

### SECTION D PROPOSED INSURED(S) INFORMATION (LIST CHILDREN AGES 14 DAYS TO 17 YEARS)

| First Name, Middle Initial, Last Name | Date of Birth | Sex M/F | Coverage Amount | Premium | Owner Relationship to Insured | Legal Permanent Resident of the United States?           |
|---------------------------------------|---------------|---------|-----------------|---------|-------------------------------|--|
|                                       |               |         |                 | \$      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                       |               |         |                 | \$      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                       |               |         |                 | \$      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                       |               |         |                 | \$      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                       |               |         |                 | \$      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                       |               |         |                 | \$      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                       |               |         |                 | \$      |                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |

NOTE: Use additional sheet if necessary.

### SECTION E OTHER COVERAGE AND REPLACEMENT INFORMATION

Do any of the Proposed Insureds:

1. have any existing life insurance or annuity contracts with the company or any other company?.....  Yes  No
2. intend for this insurance to replace or change any existing life insurance or annuity contract with the company or any other company? .....  Yes  No

IF "YES" to either question, GIVE DETAILS BELOW:

| Proposed Insured's Name | Company | Policy Number | Will this insurance be replaced?                         |
|-------------------------|---------|---------------|--|
|                         |         |               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                         |         |               | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**THE PRODUCER SHALL COMPLY WITH ANY ADDITIONAL STATE AND/OR COMPANY REPLACEMENT REQUIREMENTS.**

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**SECTION F HEALTH INFORMATION**

**HAVE ANY OF THE PROPOSED INSUREDS BEEN DIAGNOSED OR TREATED BY A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR:**

- (a) a heart or circulatory system disease, birth defect, or mental or developmental disorder including autism and Down's Syndrome?  Yes  No
- (b) any other chronic medical condition which has required care within the past 3 years?.....  Yes  No

**NOTE:** Provide details for "Yes" answers. Please include Proposed Insured's name and illness or condition. (Use additional sheet if necessary.)

| Proposed Insured's Name | Details of Illness or Condition |
|-------------------------|---------------------------------|
|                         |                                 |
|                         |                                 |
|                         |                                 |
|                         |                                 |
|                         |                                 |
|                         |                                 |
|                         |                                 |
|                         |                                 |
|                         |                                 |

**SECTION G PREMIUM AND BILLING INFORMATION**

- 1 Amount collected \$ \_\_\_\_\_ Modal Premium for Proposed Insured(s) \$ \_\_\_\_\_
- 2 Mode of Payment:  Monthly Bank Service Plan  Annual  Semi-Annual  Quarterly

**SECTION H AGREEMENT**

I represent that my above answers are true and complete to the best of my knowledge and belief. I also understand that this coverage will not be in force until this application is completed in full and approved by United of Omaha Life Insurance Company, and the initial premium is received during the lifetime of the Proposed Insured(s).

**Fraud Warning:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**I have read and understand this Agreement Section and I approve all the answers as recorded in this application.**

Signed at: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Today's Date: \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

\_\_\_\_\_  
Signature of Owner/Applicant

- 1 In addition to the above Agreement, has the Applicant informed you, the Producer(s), that any Proposed Insured has one or more existing life insurance policies and/or annuity contracts in force?.....  Yes  No
- 2 Do you, the Producer(s), have reason to believe that the policy applied for has replaced or will replace any existing life insurance policy(ies) and/or annuity contract(s)? .....  Yes  No  
If "Yes," the Producer(s) shall comply with all state and/or Company replacement requirements, including completing the applicable state required replacement forms and submitting copies of these forms with the application.
- 3 Have you, the Producer(s), asked each question exactly as written and recorded the answer completely and accurately? ...  Yes  No  
(If "No," explain.) \_\_\_\_\_
- 4 Did you, the Producer(s), give the Applicant the Life Insurance Buyer's Guide?.....  Yes  No  
(If "No," explain.) \_\_\_\_\_

\_\_\_\_\_  
Signature of Producer #1 \_\_\_\_\_ Production Number \_\_\_\_\_ Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

\_\_\_\_\_  
Signature of Producer #2 \_\_\_\_\_ Production Number \_\_\_\_\_ Date \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

\_\_\_\_\_  
Print or Stamp Producer #1 Name \_\_\_\_\_ Print or Stamp Producer #2 Name \_\_\_\_\_ Marketer/Agency Name \_\_\_\_\_

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# UNITED OF OMAHA LIFE INSURANCE COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175, 402-342-7600



## PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: \_\_\_\_\_ Policy Number(s) if known: \_\_\_\_\_

**Complete this form only when authorizing a bank account for withdrawal for a premium payment.**

### PAYMENT INFORMATION FOR THE FIRST PAYMENT- CAN BE DIFFERENT THAN THE ONGOING PAYMENTS

**Initial Premium Payment (select only one option)** Amount Quoted \$ \_\_\_\_\_

- Deduct premium immediately upon approval/issue
- Deduct initial premium on or after: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (Please Note: If the policy issue is after the date selected, the initial payment will be deducted on the date the policy is issued or all delivery requirements are received.)
- Check collected and mailed to Mutual of Omaha

Money will be deducted from your account as stated above. The first deduction may occur on a date different than the ongoing payments. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first deduction may exceed one regular payment amount. We **CANNOT** establish electronic payments from foreign banks.

### PAYMENT INFORMATION FOR ONGOING PAYMENTS- AUTOMATIC BANK ACCOUNT DEDUCTION

**Ongoing Automatic Monthly Premium Payments (Once a Month)- Select only one option**

- Choose the day payments will be deducted every month from your bank account:  
(1st through the 28th or Last Day of every month) \_\_\_\_\_  
-OR-
- Choose the week and weekday that payments will be deducted every month from your bank account:  
(For example, 3rd Wednesday of every month)

**Week (1st, 2nd, 3rd, 4th, Last)** \_\_\_\_\_ **Weekday (Mon, Tue, Wed, Thu, Fri)** \_\_\_\_\_

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date lands on a weekend or holiday, the payment will process on the following business day.**

### PAYOR INFORMATION

Name of payor as shown on bank account: \_\_\_\_\_

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation may be required)

- Employer  Living Trust
- Business owned by Proposed Insured/Insured or spouse  Other \_\_\_\_\_
- Power of Attorney or legal guardian

### PAYOR ACCOUNT INFORMATION

1. Account Type (check one):  Checking  Savings

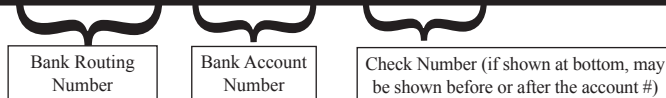
2. Name of Financial Institution: \_\_\_\_\_

3. Complete information below or attach a voided check here.

Bank Routing Number: \_\_\_\_\_ Bank Account Number: \_\_\_\_\_

(Do not use Debit/Credit Card numbers)

|               |                            |
|---------------|----------------------------|
| Memo _____    | Signed By: _____           |
| 1:123456789:1 | 12345678   *      1234   * |



### PAYOR AUTHORIZATION

I authorize United of Omaha Life Insurance Company to initiate any initial or recurring preauthorized electronic transfers from my account. I understand the amounts may vary as premium shortages may result from a variety of reasons, including underwriting adjustments. This authorization will be effective until I give you at least three business days notice to cancel. If notice is given verbally, United of Omaha Life Insurance Company may require written confirmation within 15 days after my verbal notice.

Date \_\_\_\_\_ X \_\_\_\_\_

Mo./Day/Yr.

Payor Authorized Signature as Shown on Account

**UNITED OF OMAHA LIFE INSURANCE COMPANY**

A MUTUAL of OMAHA COMPANY

**Notice Regarding Replacement of Life Insurance or Annuity  
Replacing Your Life Insurance Policy or Annuity?**

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one — or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the insurance producer or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

After we issue your policy, you will have 20 days from the date the new policy is delivered to you to cancel the policy and receive back all payments you made to us.

The following policy(policies) may be replaced as a result of this transaction:

| Insurer as it appears<br>on the policy | Insured as it appears<br>on the policy | Policy*<br>Number |
|--|--|-------------------|
| _____                                  | _____                                  | _____             |
| _____                                  | _____                                  | _____             |
| _____                                  | _____                                  | _____             |
| _____                                  | _____                                  | _____             |

\*Application or receipt number, if policy has not yet been issued.

If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months?  YES  NO

|  |               |   |
|--|---------------|---|
| _____<br>Applicant's/Owner's Signature | _____<br>Date | _____<br>Insurance Producer's Signature |
|--|---------------|---|

**ATTENTION CONSUMER.** THIS NOTICE IS REQUIRED BY THE INSURANCE COMMISSIONER. PLEASE READ IT CAREFULLY BEFORE SIGNING.



**UNITED OF OMAHA LIFE INSURANCE COMPANY**

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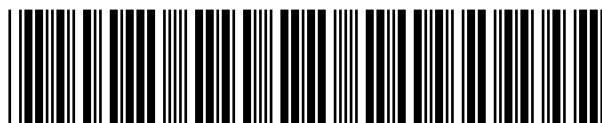
| Insurer as it appears<br>on the policy | Insured as it appears<br>on the policy | Policy*<br>Number |
|--|--|-------------------|
| _____                                  | _____                                  | _____             |
| _____                                  | _____                                  | _____             |
| _____                                  | _____                                  | _____             |
| _____                                  | _____                                  | _____             |

\*Application or receipt number, if policy has not yet been issued.

If purchasing an annuity, have you had another annuity exchange or replacement within the past 36 months?  YES  NO

|  |               |   |
|--|---------------|---|
| _____<br>Applicant's/Owner's Signature | _____<br>Date | _____<br>Insurance Producer's Signature |
|--|---------------|---|

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**UNITED OF OMAHA LIFE INSURANCE COMPANY**

A MUTUAL of OMAHA COMPANY

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**Notice Regarding Proposed Replacement  
Of Life Insurance Or Annuity**

Name of Existing Insurer

\_\_\_\_\_  
Address of Existing Insurer

\_\_\_\_\_

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity (annuities) for an individual presently insured with your company.

**Identification**

Name of Insured \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Your Contract Number(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This notice is given pursuant to 50 ILL. ADM. CODE 917.70(c)

\_\_\_\_\_  
Insurance Producer's Signature

\_\_\_\_\_  
Date







**UNITED OF OMAHA LIFE INSURANCE COMPANY**

A MUTUAL of OMAHA COMPANY

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**Notice Regarding Proposed Replacement  
Of Life Insurance Or Annuity**

Name of Existing Insurer

\_\_\_\_\_  
Address of Existing Insurer  
\_\_\_\_\_

You are herewith given notice that we are in receipt of application(s) for life insurance or annuity (annuities) for an individual presently insured with your company.

**Identification**

Name of Insured \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Your Contract Number(s) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This notice is given pursuant to 50 ILL. ADM. CODE 917.70(c)

\_\_\_\_\_  
Insurance Producer's Signature

\_\_\_\_\_  
Date



