United of Omaha Life Insurance Company
A Mutual *of* Omaha Company

Pennsylvania – Application for Life Insurance

Living Promise Product – One Base Policy per Application

✍ ***Checklist for Submitting a Complete Application***

Please mail application and appropriate forms to: United of Omaha Life Insurance Company,
Attn: Individual Life Underwriting, 9330 State Hwy 133, Blair, NE 68008
FAX: 1-402-997-1800

☞ Please choose the precise Plan, Rider, and amount of insurance applied for

❑ **Level Benefit Product:**	❑ **Graded Benefit Product (if available):**
• Accelerated Death Benefit Rider • Accidental Death Benefit Rider (optional)	• No Riders Available

Application Submission Guidelines

- ❑ Attach a cover letter or additional information as needed.
- ❑ Always submit the Producer Report page.
- ❑ Leave all applicable forms and Life Buyer's Guide with the Proposed Insured.
- ❑ All changes should be initialed by the Applicant/Owner.
- ❑ 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
- ❑ Conditional Receipt – Complete ONLY if you accepted a check or electronic transaction authorization at time of application for the initial premium. **DO NOT** complete the Conditional Receipt if initial payment won't be collected until issue.
- ❑ Accelerated Benefit Rider Disclosure – The client must sign the Accelerated Benefit Rider Disclosure Form
- ❑ Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor - Complete this form if applicable. The client must sign and retain a copy for their records.

Supplemental Forms and Buyer's Guide:

- ***Buyer's Guide:*** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale.

United of Omaha Life Insurance Company

A Mutual of Omaha Company
Mutual of Omaha Plaza, Omaha, NE 68175

Application for Individual Life Insurance

PROPOSED INSURED

Name (First, Middle Initial, Last)	Sex ☐ Male ☐ Female	Height	Weight	Social Security No.

Home Address (Street, City, State, Zip)	State of Birth	Date of Birth	Age

Phone No.	E-mail	Driver's License No.	Driver's License State

Are you a legal resident of the United States? ☐ **Yes** ☐ **No**
(If "No", you are not eligible for coverage.)

In the past 12 months, has the Proposed Insured used any form of tobacco or nicotine replacement therapy? ☐ **Yes** ☐ **No**

OWNER (Complete only if Owner/Applicant is different from Proposed Insured)

Name of Policyowner (First, Middle Initial, Last)	Relationship to Proposed Insured

Policyowner Address (Street, City, State, Zip)	Phone No.	Social Security No.

Sex ☐ Male ☐ Female	Date of Birth	Age	E-mail	Citizenship Country

UNDERWRITING

Part One **IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN PART ONE, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.**

1. Is the Proposed Insured currently:
- **(a)** bedridden or confined to any hospital, nursing home, long-term care facility or skilled nursing facility; or receiving or been advised to receive care in a nursing home, hospice care, or home health care? . . . . ☐ **Yes** ☐ **No**
- **(b)** requiring assistance with activities of daily living such as taking medications, bathing, dressing, eating, toileting, getting in and out of a chair or bed, or control of bowel or bladder problems? . . . . . ☐ **Yes** ☐ **No**
- **(c)** requiring any of the following (other than for fractures, bone or joint surgery, including replacement): wheelchair, electric scooter, or oxygen equipment to assist breathing (excluding use for sleep apnea)? . . . . . ☐ **Yes** ☐ **No**

2. Has the Proposed Insured **ever been**:
- **(a)** diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or heath care provider? . . . . . ☐ **Yes** ☐ **No**
- **(b)** diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Quadriplegia, Paraplegia, Down's Syndrome, mental incapacity, congestive heart failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type? . . . . . ☐ **Yes** ☐ **No**
- **(c)** diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed with End Stage Renal Disease or requiring dialysis?. . . . . ☐ **Yes** ☐ **No**
- **(d)** advised to receive or have received an organ or bone marrow transplant?. . . . . ☐ **Yes** ☐ **No**
- **(e)** diagnosed by a physician or health care provider as having a terminal medical condition that is expected to result in death within the next twelve 12 months?. . . . . ☐ **Yes** ☐ **No**

3. In the past 12 months, has the Proposed Insured been:
- **(a)** advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known? . . . . . ☐ **Yes** ☐ **No**
- **(b)** diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind? . . ☐ **Yes** ☐ **No**

4. In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for any form of cancer (except basal or squamous cell skin cancer)? . . . . . ☐ **Yes** ☐ **No**

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Part Two **IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTION IN PART TWO, THAT PERSON IS ELIGIBLE ONLY FOR THE GRADED BENEFIT PRODUCT.**

5. Has the Proposed Insured **ever** (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Diabetes before age 50 or diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)?	☐ **Yes** ☐ **No**
(b) Hepatitis C?	☐ **Yes** ☐ **No**
(c) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?	☐ **Yes** ☐ **No**
6. **In the past 4 years**, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)?	☐ **Yes** ☐ **No**
(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?	☐ **Yes** ☐ **No**
(c) Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis?	☐ **Yes** ☐ **No**
7. **In the past 2 years**, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement?	☐ **Yes** ☐ **No**
(b) Stroke or Transient Ischemic Attack (TIA)?	☐ **Yes** ☐ **No**
8. **In the past 2 years**, has the Proposed Insured:	
(a) been convicted of or currently awaiting trial for a felony?	☐ **Yes** ☐ **No**
(b) been treated for or advised to have treatment for alcohol or drug abuse or convicted more than once of reckless driving or driving under the influence of drugs or alcohol?	☐ **Yes** ☐ **No**
(c) used unlawful drugs in any form or abused or misused prescription drugs?	☐ **Yes** ☐ **No**
9. **In the past 2 years**, has the Proposed Insured been hospitalized by a physician or health care provider for any mental or nervous disorder?	☐ **Yes** ☐ **No**
10. **In the past 12 months,** has the Proposed Insured consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding?	☐ **Yes** ☐ **No**

NOTE: If the Proposed Insured answers all above questions "No", that person is eligible for the Level Benefit Product.

OPTIONAL COMMENTS (Not Required) - Provide any additional information available.

Question Number	Details to Underwriting Questions (Diagnosis, Dates, Durations, Medications, Dosages)

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PLAN INFORMATION

Plan:	Rider: (Only if selecting Level Benefit Product)
☐ Level Benefit Product ☐ Graded Benefit Product Amount Applied For $ _____	☐ Accidental Death Rider

Payment Mode:

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (Automated Bank Account Withdrawal)

Modal Premium $_____ Collected Premium $_____

BENEFICIARY (If more space is needed, list on a separate sheet)

Primary Beneficiary	Relationship to Insured	Date of Birth
Contingent Beneficiary	Relationship to Insured	Date of Birth

OTHER COVERAGE INFORMATION

1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company? . . . . . ☐ **Yes** ☐ **No**

2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with the company or any other company? . . . . . ☐ **Yes** ☐ **No**

If "Yes" to questions #1 or #2, please give details below. If more space is needed, list on a separate sheet.

Company	Proposed Insured	Face Amount	To be Replaced or Converted?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

AUTHORIZATION and AGREEMENT

Authorization: I authorize any medical provider, hospital, clinic, pharmacy, pharmacy benefit manager, or other medical care facility, MIB, Inc. (MIB), state department of motor vehicles and other entities processing motor vehicle records, insurance companies or consumer reporting agencies to release information about me or my health, such as, medical history, including the presence of HIV infection, AIDS or ARC, mental or physical condition, prescription drug records, drug or alcohol use, driving record or insurance claims information, to United of Omaha Life Insurance Company ("United of Omaha"). The information will be used to determine my eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise. I also authorize United of Omaha to disclose information to MIB. I understand that my information received by MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits. If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations. This authorization is valid for 24 months from the date signed. I may refuse to sign this authorization but if I refuse, the insurance I am applying for will not be issued. I may revoke this authorization at any time by written notice to the address below. This revocation is limited to the extent that United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha to contest the issuance of the policy or a claim under the policy. I will receive a copy of this authorization.

Agreement: To the best of my knowledge and belief, I represent the information above is true and complete. Any incorrect or misleading answers may void this application and any issued policy effective the issue date. Unless otherwise provided under a conditional receipt, I understand that no insurance shall take effect until all outstanding application requirements have been received, a policy is issued and the first premium is received by United of Omaha during the Proposed Insured's lifetime. The issue date of the policy will be the date shown on the policy, even though coverage may not become effective until a later date. You must immediately notify United of Omaha if there has been a change in the Proposed Insured's health or habits that will change any statement or answer to any question in the application as of the date the policy is delivered. No policy of any kind will be in effect if the Proposed Insured dies or is otherwise ineligible for the insurance for which they applied. No producer can waive or change any receipt or policy provision or agree to issue any policy.

- CONTINUED ON NEXT PAGE -

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.
If applying for the Graded Benefit Product: I understand that a reduced death benefit amount is payable during the first two policy years if death results from sickness or other natural causes. The full face amount is payable during the first two policy years if death results from an accident.

Signed at:_____

City State

_____ Date: _____
Signature of Proposed Insured

_____ Date: _____
Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)

Producer Statement:

By signing below, I/we, the Producer(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

1. I/We certify that, during an interview with the Proposed Insured, I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. . . . . ☐ **Yes** ☐ **No**
2. Do you, the Producer(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy or annuity contract in force with the company or any other company? . . . . . ☐ **Yes** ☐ **No**
3. Has the Proposed Insured informed you, the Producer(s), that he/she has any pending or existing life insurance or annuity contracts with the company or any other company?. . . . . ☐ **Yes** ☐ **No**
   (If the above questions are answered "Yes," fulfill all state and company requirements.)
4. Are you related to the Proposed Insured or Owner? . . . . . ☐ **Yes** ☐ **No**
   If "Yes," state relationship _____
5. How long have you known the Proposed Insured? _____
6. How long have you known the Proposed Owner? _____
7. Previous residence of Proposed Insured for the past five years.

Street Address	City	State	Zip Code

8. I/We conducted said interview in person . . . . . ☐ **Yes** ☐ **No**

If "No," please explain _____

_____ _____ _____ _____
Signature of Producer #1 Producer E-mail Production Number Date

_____ _____ _____ _____
Signature of Producer #2 Producer E-mail Production Number Date

_____ _____ _____
Print Producer #1 Name Print Producer #2 Name Agency Name

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Producer Report

1 Was a Personal Health Interview (PHI) conducted by Apptical Corporation as a part of the application process?.....☐ Yes ☐ No

If Yes, please provide the PHI number_____

2 List any additional information or comments below:

_____

_____

_____

_____

_____

_____

_____

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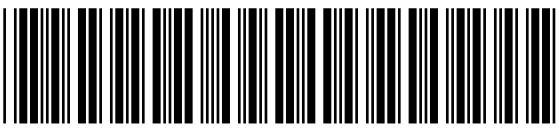


United of Omaha Life Insurance Company

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

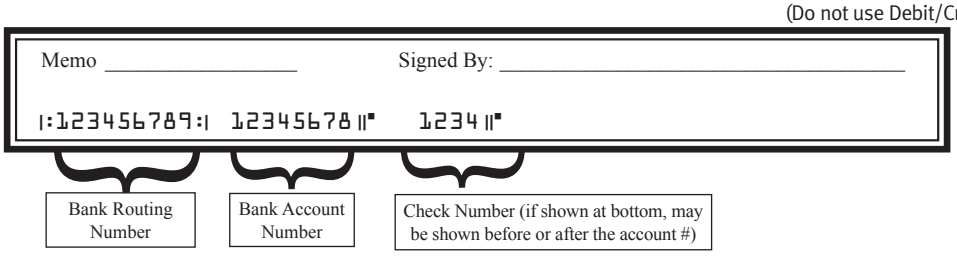
Name of payor as shown on bank account: _____

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
- ☐ Business owned by Proposed Insured/Insured or spouse
- ☐ Power of Attorney or legal guardian
- ☐ Living Trust
- ☐ Other _____

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)



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

Conditional Receipt ("Receipt")

United of Omaha Life Insurance Company ("United", "we"), Mutual of Omaha Plaza, Omaha, NE 68175

If any proposed insured dies while coverage under this Receipt is in effect, we will pay to the beneficiary(ies) named in the application the amount described in the section below entitled "Benefit".

Date of Receipt:_____

Benefit

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) $40,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed $40,000.

Conditions

Conditions under which a benefit may be payable under this Receipt prior to policy delivery:

1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and
2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and
3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and
4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.

If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.

End Date

This Receipt and any coverage provided hereunder will **END** on the earliest of the following dates:
1 60 days from the date of this Receipt; or
2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 The date the Applicant/Owner withdraws the application for insurance.

Signatures

This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.

I/We have read and received a copy of this Receipt and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

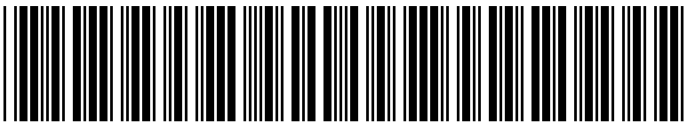
_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized $_____

I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date



Disclosure Statement

Direct all correspondence to : United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

This Disclosure Statement is for your protection. It gives you basic information about the cost and coverage of the insurance being solicited. Read it carefully before signing the accompanying application.

This Disclosure Statement shall not be considered as an offer to contract or as altering or modifying any policy or rider that may be issued.

Proposed Insured Name: _____ Sex _____ Age _____

Descriptive Title of Coverage:

Level premium Whole Life Insurance paid up at age 100.

Issue ages are 45-85. The annual policy fee is $36.00

Face Amount $_____ Annual Premium $_____

If you pay your premiums on this policy as they come due, you will have the guaranteed cash values shown on the reverse side of this form. You may borrow against this cash value at an annual interest rate of 7.4% payable in advance.

A surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one method of comparing the relative costs of two or more similar policies. If an earlier copy of the Index is necessary, call toll free 1-800-228-9999.

Upon request, the Company will furnish you with additional information about the insurance described.

Riders Included:

Accidental Death Benefit Annual Premium $ _____

Accelerated Death Benefit
(the cost is included in the premium of the policy) Total Premium $ _____

I certify that a copy of this Disclosure Statement was given to the Applicant no later than the time the application was signed.

Date: _____

Licensed Agent's Signature: _____

Address: (city, state, zip) _____

Phone: _____

BASIC CASH VALUES PER $1,000 OF INSURANCE*

Issue Age	MALE NON-TOBACCO				MALE TOBACCO				FEMALE NON-TOBACCO				FEMALE TOBACCO			
	At End of policy Year			At Age 65	At End of policy Year			At Age 65	At End of policy Year			At Age 65	At End of policy Year			At Age 65
	5	10	20		5	10	20		5	10	20		5	10	20	
45	42	124	312	312	49	142	338	338	35	104	263	263	46	128	305	305
46	45	129	323	302	52	147	347	327	37	108	273	255	47	132	313	294
47	47	135	334	292	54	152	356	316	39	112	282	245	49	135	321	283
48	50	141	345	282	57	158	365	304	40	116	292	235	50	139	330	271
49	53	147	357	270	59	163	375	290	42	120	302	225	51	142	339	258
50	55	153	368	258	61	168	384	276	44	125	313	214	53	146	348	245
51	57	159	381	245	63	173	394	261	45	129	323	203	54	150	357	231
52	60	165	393	231	65	178	404	245	47	134	334	190	55	154	366	216
53	62	171	405	216	66	182	414	228	49	139	346	178	56	158	376	201
54	65	177	417	200	68	187	424	210	51	144	357	164	58	163	385	185
55	67	183	430	183	70	191	435	191	53	150	369	150	59	168	395	168
56	70	190	443	166	72	195	445	171	55	156	381	135	61	173	404	150
57	73	196	456	146	74	200	456	150	57	162	394	119	62	178	414	131
58	76	203	469	126	76	205	467	127	59	168	407	102	64	184	425	111
59	78	210	481	104	77	210	478	103	62	175	420	84	66	189	435	90
60	81	218	494	81	78	216	489	78	65	182	433	65	68	195	445	68
61	83	225	506	56	81	224	500	53	67	189	447	44	70	201	456	44
62	86	233	518	29	84	232	511	27	70	196	460	23	72	207	465	19
63	88	241	529	0	88	241	522	0	73	204	474	0	76	214	475	0
64	92	250	541	0	93	250	533	0	77	212	487	0	80	222	485	0
65	98	260	553	-	99	260	544	-	80	219	500	-	85	229	494	-
66	105	271	564	-	105	270	554	-	83	228	513	-	90	237	503	-
67	111	282	575	-	111	280	563	-	86	236	526	-	94	245	512	-
68	118	293	585	-	118	290	571	-	90	244	539	-	99	253	520	-
69	124	304	594	-	124	300	578	-	95	255	552	-	103	261	527	-
70	131	314	602	-	130	309	584	-	101	266	565	-	108	270	534	-
71	137	324	610	-	136	317	589	-	107	278	580	-	112	278	544	-
72	144	333	618	-	142	325	595	-	114	289	599	-	117	286	559	-
73	151	343	627	-	148	333	601	-	121	300	619	-	122	292	577	-
74	158	351	638	-	154	340	610	-	128	310	642	-	127	298	599	-
75	164	360	651	-	159	347	622	-	135	321	667	-	133	304	624	-
76	170	367	671	-	163	352	641	-	143	332	696	-	139	310	654	-
77	175	373	703	-	167	357	672	-	150	343	733	-	143	315	693	-
78	179	378	755	-	170	360	727	-	156	353	788	-	146	319	754	-
79	184	382	840	-	174	362	824	-	162	363	872	-	148	322	850	-
80	188	386	843	-	177	362	1000	-	168	372	1000	-	149	324	1000	-
81	192	389	1000	-	180	363	1000	-	175	384	1000	-	151	331	1000	-
82	195	393	1000	-	182	364	1000	-	181	402	1000	-	153	346	1000	-
83	197	399	1000	-	183	367	1000	-	188	424	1000	-	155	367	1000	-
84	198	408	1000	-	181	374	1000	-	194	449	1000	-	156	394	1000	-
85	198	423	1000	-	179	387	1000	-	200	480	1000	-	159	427	1000	-

* The cash values are provided to demonstrate the cash flow pattern of the policy. They do not recognize that, because of interest, a dollar in the future has less value than a dollar today.

Disclosure Statement

Direct all correspondence to : United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

This Disclosure Statement is for your protection. It gives you basic information about the cost and coverage of the insurance being solicited. Read it carefully before signing the accompanying application.

This Disclosure Statement shall not be considered as an offer to contract or as altering or modifying any policy or rider that may be issued.

Proposed Insured Name: _____ Sex _____ Age _____

Descriptive Title of Coverage:

Level premium Whole Life Insurance paid up at age 100 with a Graded Death Benefit for the first two years.

If you die of natural causes in the first two years, the graded death benefit is 110% of the annual premium; in the third year or later, full face amount. If death in any policy year results directly from accidental bodily injury and independently of all other causes, the death benefit will be the full face amount shown.

Issue ages are 45-80. The annual policy fee is $36.00

Face Amount $_____ Annual Premium $_____

If you pay your premiums on this policy as they come due, you will have the guaranteed cash values shown on the reverse side of this form. You may borrow against this cash value at an annual interest rate of 7.4% payable in advance.

A surrender Comparison Index will be provided upon delivery of the policy or earlier if requested. This Index provides one method of comparing the relative costs of two or more similar policies. If an earlier copy of the Index is necessary, call toll free 1-800-228-9999.

Upon request, the Company will furnish you with additional information about the insurance described.

I certify that a copy of this Disclosure Statement was given to the Applicant no later than the time the application was signed.

Date: _____

Licensed Agent's Signature: _____

Address: (city, state, zip) _____

Phone: _____

MALE

BASIC CASH VALUE PER $1,000 OF INSURANCE*

Issue Age	At End of policy Year			At Age 65
	5	10	20	
45	50	132	319	319
46	53	138	330	310
47	55	143	341	300
48	58	149	352	289
49	61	155	363	278
50	64	162	375	266
51	67	168	387	253
52	70	175	399	240
53	73	181	412	226
54	76	188	424	211
55	80	195	437	195
56	84	202	450	178
57	88	209	463	160
58	91	216	476	141
59	95	224	489	120
60	98	232	502	98
61	103	241	515	76
62	109	252	528	54
63	115	263	541	30
64	122	274	554	0
65	130	286	567	0
66	138	298	579	-
67	146	310	590	-
68	154	322	600	-
69	163	334	610	-
70	171	346	619	-
71	180	357	627	-
72	189	367	636	-
73	198	378	645	-
74	207	388	656	-
75	216	398	670	-
76	223	406	690	-
77	230	414	720	-
78	236	420	770	-
79	243	426	853	-
80	249	430	1000	-

FEMALE

BASIC CASH VALUE PER $1,000 OF INSURANCE*

Issue Age	At End of policy Year			At Age 65
	5	10	20	
45	41	110	270	270
46	43	114	279	261
47	45	119	288	252
48	47	123	298	242
49	50	128	309	232
50	52	133	319	222
51	54	138	330	211
52	56	143	341	199
53	59	148	353	187
54	61	154	364	174
55	64	160	376	160
56	67	167	389	146
57	70	173	402	131
58	73	180	415	115
59	77	188	428	98
60	80	195	442	80
61	84	203	456	61
62	88	211	469	41
63	92	220	483	19
64	96	228	496	0
65	101	237	509	0
66	107	247	524	-
67	114	258	538	-
68	121	269	552	-
69	128	281	565	-
70	135	293	579	-
71	143	305	594	-
72	151	317	613	-
73	159	329	633	-
74	168	341	656	-
75	177	353	681	-
76	186	364	709	-
77	195	376	746	-
78	203	387	798	-
79	211	398	878	-
80	220	409	1000	-

* The cash values are provided to demonstrate the cash flow pattern of the policy. They do not recognize that, because of interest, a dollar in the future has less value than a dollar today.

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefit received under the rider may be taxable. Receipt of the accelerated death benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting the benefit.

This disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness or Nursing Home Confinement Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

While the rider is in force and the insured has a terminal illness or is under nursing home confinement, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. Nursing home confinement means that the insured has been confined to a nursing home for at least 90 consecutive days and is expected to remain confined for the remainder of his or her life. A physician must certify that the insured has a terminal illness or is under nursing home confinement.

The amount available for the accelerated death benefit is your policy's death benefit. You may receive the accelerated death benefit only once.

For a terminal illness, we will reduce the accelerated death benefit by 6%.

For nursing home confinement, we will reduce the accelerated death benefit by the nursing home confinement factor. The nursing home confinement factor varies by policy year as shown in the rider. We will also reduce the accelerated death benefit by a $100 charge and by the amount of any loans and unpaid premiums.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The rider will terminate when the accelerated death benefit is paid.

NOTE: If the policy is issued as a graded death benefit, the accelerated death benefit is not available.

Acknowledgment

I acknowledge receipt of this disclosure form.

_____ _____
Applicant/Owner Signature Date

I have provided this disclosure form to the applicant/owner.

_____ _____
Producer Signature Date

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Companion Life Insurance Company

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

CLIENT FORMS

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s).

Conditional Receipt ("Receipt")

United of Omaha Life Insurance Company ("United", "we"), Mutual of Omaha Plaza, Omaha, NE 68175

If any proposed insured dies while coverage under this Receipt is in effect, we will pay to the beneficiary(ies) named in the application the amount described in the section below entitled "Benefit".

Date of Receipt:_____

Benefit

For purposes of this Receipt, the benefit under this Receipt is an amount equal to the lesser of: (1) the amount of the death benefit that would be payable in the first policy year under the policy as applied for in the application; or (2) $40,000 minus the amount of any insurance on the Proposed Insured's life under any other temporary insurance agreements and/or conditional receipts. In no event will the amount of the Conditional Receipt benefit under this Receipt exceed $40,000.

Conditions

Conditions under which a benefit may be payable under this Receipt prior to policy delivery:

1 The amount received via check or authorized electronic transaction with the application is sufficient to pay: (a) the first premium of a fixed premium plan at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan; and
2 Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United then in effect, without modification of the plan, premium rate, benefits, class and amounts of coverage applied for; and
3 To the best knowledge and belief of those signing the application, all the statements and answers in the application are true and complete when made; and
4 All parts of the application, and if required, exams, supplements to the application, questionnaires and amendments to the application, are completed and received by United.

If a Proposed Insured dies by suicide or self-inflicted injury, while sane or insane, United will not be liable under this Receipt except to return any payment paid with the application.

End Date

This Receipt and any coverage provided hereunder will **END** on the earliest of the following dates:

1 60 days from the date of this Receipt; or
2 The date we deliver the policy applied for to the Applicant/Owner and all delivery requirements have been completed; or
3 The date we mail you a letter notifying you that we: (a) are unable to approve the requested coverage at the risk class applied for; or (b) have declined to issue you a policy; or (c) will not provide conditional receipt coverage; or
4 The date the Applicant/Owner withdraws the application for insurance.

Signatures

This Receipt does not limit United in applying its underwriting standards to the application nor does this Receipt limit or waive any rights under any life insurance policy issued. If United rejects or declines the application, United will refund the applicant any premium paid with the application.

I/We have read and received a copy of this Receipt and understand and agree to all of its terms. I/We verify the above answers are true and complete to the best of my/our knowledge and belief. I/We understand that the Producer has no authority to change the terms of this Receipt.

_____ _____
Signature of Proposed Insured Date

_____ _____
Signature of Other Proposed Insured Date

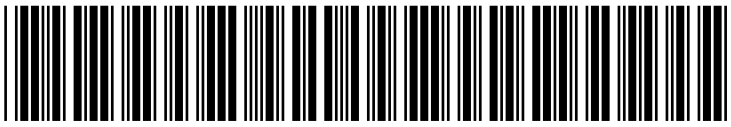
_____ _____
Signature of Applicant/Owner (if other than Proposed Insured) Date

Payment Method: Check ☐ Electronic Transaction Authorization ☐ Amount remitted/authorized $_____

I/We agree that I/We am/are not authorized to change or waive the terms of this Receipt and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Receipt to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

_____ _____
Signature of Producer Date

_____ _____
Signature of Producer Date



United of Omaha Life Insurance Company - MIB Group, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. United of Omaha Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of 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 MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. 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 is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

United of Omaha Life Insurance Company, or its reinsurers, may also release information in its file to other 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.

Applicant's/Owner's Copy L7941

Disclosure Statement

Direct all correspondence to : United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

This Disclosure Statement is for your protection. It gives you basic information about the cost and coverage of the insurance being solicited. Read it carefully before signing the accompanying application.

This Disclosure Statement shall not be considered as an offer to contract or as altering or modifying any policy or rider that may be issued.

Proposed Insured Name: _____ Sex _____ Age _____

Descriptive Title of Coverage:

Level premium Whole Life Insurance paid up at age 100.

Issue ages are 45-85. The annual policy fee is $36.00

Face Amount $_____ Annual Premium $_____

If you pay your premiums on this policy as they come due, you will have the guaranteed cash values shown on the reverse side of this form. You may borrow against this cash value at an annual interest rate of 7.4% payable in advance.

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Upon request, the Company will furnish you with additional information about the insurance described.

Riders Included:

Accidental Death Benefit Annual Premium $ _____

Accelerated Death Benefit
(the cost is included in the premium of the policy) Total Premium $ _____

I certify that a copy of this Disclosure Statement was given to the Applicant no later than the time the application was signed.

Date: _____

Licensed Agent's Signature: _____

Address: (city, state, zip) _____

Phone: _____

BASIC CASH VALUES PER $1,000 OF INSURANCE*

Issue Age	MALE NON-TOBACCO				MALE TOBACCO				FEMALE NON-TOBACCO				FEMALE TOBACCO			
	At End of policy Year			At Age 65	At End of policy Year			At Age 65	At End of policy Year			At Age 65	At End of policy Year			At Age 65
	5	10	20		5	10	20		5	10	20		5	10	20	
45	42	124	312	312	49	142	338	338	35	104	263	263	46	128	305	305
46	45	129	323	302	52	147	347	327	37	108	273	255	47	132	313	294
47	47	135	334	292	54	152	356	316	39	112	282	245	49	135	321	283
48	50	141	345	282	57	158	365	304	40	116	292	235	50	139	330	271
49	53	147	357	270	59	163	375	290	42	120	302	225	51	142	339	258
50	55	153	368	258	61	168	384	276	44	125	313	214	53	146	348	245
51	57	159	381	245	63	173	394	261	45	129	323	203	54	150	357	231
52	60	165	393	231	65	178	404	245	47	134	334	190	55	154	366	216
53	62	171	405	216	66	182	414	228	49	139	346	178	56	158	376	201
54	65	177	417	200	68	187	424	210	51	144	357	164	58	163	385	185
55	67	183	430	183	70	191	435	191	53	150	369	150	59	168	395	168
56	70	190	443	166	72	195	445	171	55	156	381	135	61	173	404	150
57	73	196	456	146	74	200	456	150	57	162	394	119	62	178	414	131
58	76	203	469	126	76	205	467	127	59	168	407	102	64	184	425	111
59	78	210	481	104	77	210	478	103	62	175	420	84	66	189	435	90
60	81	218	494	81	78	216	489	78	65	182	433	65	68	195	445	68
61	83	225	506	56	81	224	500	53	67	189	447	44	70	201	456	44
62	86	233	518	29	84	232	511	27	70	196	460	23	72	207	465	19
63	88	241	529	0	88	241	522	0	73	204	474	0	76	214	475	0
64	92	250	541	0	93	250	533	0	77	212	487	0	80	222	485	0
65	98	260	553	-	99	260	544	-	80	219	500	-	85	229	494	-
66	105	271	564	-	105	270	554	-	83	228	513	-	90	237	503	-
67	111	282	575	-	111	280	563	-	86	236	526	-	94	245	512	-
68	118	293	585	-	118	290	571	-	90	244	539	-	99	253	520	-
69	124	304	594	-	124	300	578	-	95	255	552	-	103	261	527	-
70	131	314	602	-	130	309	584	-	101	266	565	-	108	270	534	-
71	137	324	610	-	136	317	589	-	107	278	580	-	112	278	544	-
72	144	333	618	-	142	325	595	-	114	289	599	-	117	286	559	-
73	151	343	627	-	148	333	601	-	121	300	619	-	122	292	577	-
74	158	351	638	-	154	340	610	-	128	310	642	-	127	298	599	-
75	164	360	651	-	159	347	622	-	135	321	667	-	133	304	624	-
76	170	367	671	-	163	352	641	-	143	332	696	-	139	310	654	-
77	175	373	703	-	167	357	672	-	150	343	733	-	143	315	693	-
78	179	378	755	-	170	360	727	-	156	353	788	-	146	319	754	-
79	184	382	840	-	174	362	824	-	162	363	872	-	148	322	850	-
80	188	386	843	-	177	362	1000	-	168	372	1000	-	149	324	1000	-
81	192	389	1000	-	180	363	1000	-	175	384	1000	-	151	331	1000	-
82	195	393	1000	-	182	364	1000	-	181	402	1000	-	153	346	1000	-
83	197	399	1000	-	183	367	1000	-	188	424	1000	-	155	367	1000	-
84	198	408	1000	-	181	374	1000	-	194	449	1000	-	156	394	1000	-
85	198	423	1000	-	179	387	1000	-	200	480	1000	-	159	427	1000	-

* The cash values are provided to demonstrate the cash flow pattern of the policy. They do not recognize that, because of interest, a dollar in the future has less value than a dollar today.

Disclosure Statement

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Omaha, Nebraska 68175

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If you die of natural causes in the first two years, the graded death benefit is 110% of the annual premium; in the third year or later, full face amount. If death in any policy year results directly from accidental bodily injury and independently of all other causes, the death benefit will be the full face amount shown.

Issue ages are 45-80. The annual policy fee is $36.00

Face Amount $_____ Annual Premium $_____

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Upon request, the Company will furnish you with additional information about the insurance described.

I certify that a copy of this Disclosure Statement was given to the Applicant no later than the time the application was signed.

Date: _____

Licensed Agent's Signature: _____

Address: (city, state, zip) _____

Phone: _____

MALE

BASIC CASH VALUE PER $1,000 OF INSURANCE*

Issue Age	At End of policy Year			At Age 65
	5	10	20	
45	50	132	319	319
46	53	138	330	310
47	55	143	341	300
48	58	149	352	289
49	61	155	363	278
50	64	162	375	266
51	67	168	387	253
52	70	175	399	240
53	73	181	412	226
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55	80	195	437	195
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57	88	209	463	160
58	91	216	476	141
59	95	224	489	120
60	98	232	502	98
61	103	241	515	76
62	109	252	528	54
63	115	263	541	30
64	122	274	554	0
65	130	286	567	0
66	138	298	579	-
67	146	310	590	-
68	154	322	600	-
69	163	334	610	-
70	171	346	619	-
71	180	357	627	-
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75	216	398	670	-
76	223	406	690	-
77	230	414	720	-
78	236	420	770	-
79	243	426	853	-
80	249	430	1000	-

FEMALE

BASIC CASH VALUE PER $1,000 OF INSURANCE*

Issue Age	At End of policy Year			At Age 65
	5	10	20	
45	41	110	270	270
46	43	114	279	261
47	45	119	288	252
48	47	123	298	242
49	50	128	309	232
50	52	133	319	222
51	54	138	330	211
52	56	143	341	199
53	59	148	353	187
54	61	154	364	174
55	64	160	376	160
56	67	167	389	146
57	70	173	402	131
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60	80	195	442	80
61	84	203	456	61
62	88	211	469	41
63	92	220	483	19
64	96	228	496	0
65	101	237	509	0
66	107	247	524	-
67	114	258	538	-
68	121	269	552	-
69	128	281	565	-
70	135	293	579	-
71	143	305	594	-
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* The cash values are provided to demonstrate the cash flow pattern of the policy. They do not recognize that, because of interest, a dollar in the future has less value than a dollar today.

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefit received under the rider may be taxable. Receipt of the accelerated death benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting the benefit.

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BENEFIT DESCRIPTION

While the rider is in force and the insured has a terminal illness or is under nursing home confinement, you may elect to receive the accelerated death benefit before the insured dies. A terminal illness is a medical condition that will result in the insured's death within 12 months. Nursing home confinement means that the insured has been confined to a nursing home for at least 90 consecutive days and is expected to remain confined for the remainder of his or her life. A physician must certify that the insured has a terminal illness or is under nursing home confinement.

The amount available for the accelerated death benefit is your policy's death benefit. You may receive the accelerated death benefit only once.

For a terminal illness, we will reduce the accelerated death benefit by 6%.

For nursing home confinement, we will reduce the accelerated death benefit by the nursing home confinement factor. The nursing home confinement factor varies by policy year as shown in the rider. We will also reduce the accelerated death benefit by a $100 charge and by the amount of any loans and unpaid premiums.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The rider will terminate when the accelerated death benefit is paid.

NOTE: If the policy is issued as a graded death benefit, the accelerated death benefit is not available.

Acknowledgment

I acknowledge receipt of this disclosure form.

_____ _____
Applicant/Owner Signature Date

I have provided this disclosure form to the applicant/owner.

_____ _____
Producer Signature Date

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Companion Life Insurance Company

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

United of Omaha Life Insurance Company
A Mutual *of* Omaha Company

Life Application Submission Form

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

Comments: _____

_____

_____

Name of Insured

Name of Agent	Production Number	Phone Number	Email Address

Next Highest Upline	Production Number	Phone Number	Email Address

Please list any underwriting requirements that have already been ordered by the agent or Master General Agent/Broker General Agent.

_____

_____

_____

_____

_____

_____

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

Notice Regarding Replacement of Life Insurance and Annuities

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

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

_____ _____
Applicant's/Owner's Signature Date

_____ _____
Agent's Signature Date

L4458_1205 Company's Copy

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

Notice Regarding Replacement of Life Insurance and Annuities

You have indicated that you intend to replace existing life insurance or annuity coverage in connection with the purchase of our life insurance or annuity policy. As a result, we are required to send you this notice. Please read it carefully.

Whether it is to your advantage to replace your existing insurance or annuity coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and your existing insurance or annuity coverage.

You may want to contact your existing life insurance or annuity company or its agent for additional information and advice or discuss your purchase with other advisors. Your existing company will provide this information to you. The information you receive should be of value to you in reaching a final decision.

If either the proposed coverage or the existing coverage you intend to replace is participating, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which the issuing company could contest the policy because of a material misrepresentation or omission concerning the medical information requested in your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

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After we have issued your policy, you will have 20 days from the date the new policy is received by you to notify us you are cancelling the policy issued on your application and you will receive back all payments you made to us.

You are urged not to take action to terminate or alter your existing life insurance or annuity coverage until you have been issued the new policy, examined it and have found it acceptable to you.

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

_____ _____
Applicant's/Owner's Signature Date

_____ _____
Agent's Signature Date