

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



**APPLICATION for
CHILDREN'S WHOLE LIFE INSURANCE**

CALIFORNIA

UNITED OF OMAHA LIFE INSURANCE COMPANY

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CHECKLIST FOR SUBMITTING A COMPLETED 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

Application

- 1 Answer all questions completely.
- 2 Leave all applicable forms with the proposed insured.
- 3 Sign and Date in all places indicated.

Complete Premium Collection Section

A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected. Complete the Payment Authorization form if applicable.

Financial Institution Consumer Disclosure

If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

Any Additional Information or Comments

include any supplemental information about your client

NOTE: Replacement forms can be downloaded from Sales Professional Access (SPA) at www.mutualofomaha.com as needed to accompany the application.

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION



Children's Whole Life Application

Application for Whole Life Insurance

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

Home Office Use

CWL



Mutual of Omaha

SECTION A OWNER/APPLICANT

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

| | |
|--|------------------------------|
| Legal Residence Address (Street, City, State, ZIP) | Birth Date (Month, Day Year) |
|--|------------------------------|

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

Are you a citizen of the United States?..... Yes No
 If "No," do you have an Alien Registration Receipt Card (also known as a "Permanent Residency Card" or "Green Card")?.. Yes No
 If "Yes," Card Number _____ Date of arrival in the United States _____

Beneficiary: You will be the beneficiary unless you name someone else below.

(Please Print) _____
 First Name Initial Last Name Relationship to Proposed Insured(s)

SECTION B PROPOSED INSURED(S) INFORMATION

| | First Name, Middle Initial, Last Name | Date of Birth | Sex M/F | Coverage Amount | Premium | Owner Relationship to Insured |
|---|---------------------------------------|---------------|---------|-----------------|---------|-------------------------------|
| 1 | | | | | \$ | |
| 2 | | | | | \$ | |
| 3 | | | | | \$ | |
| 4 | | | | | \$ | |
| 5 | | | | | \$ | |
| 6 | | | | | \$ | |
| 7 | | | | | \$ | |
| 8 | | | | | \$ | |

Are all Proposed Insureds citizens of the United States?..... Yes No
 If "No," do all Proposed Insureds have an Alien Registration Receipt Card (also known as a "Permanent Residency Card" or "Green Card")?.. Yes No
 If "Yes," Card Number(s) _____
 Date(s) of arrival in the United States _____
 NOTE: Use additional sheet if necessary.

SECTION C OTHER COVERAGE AND REPLACEMENT INFORMATION

- List below all life insurance policies and/or annuity contracts on any of the Proposed Insureds that are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) If none, check the following box:..... None
- Have any of the Proposed Insureds had, or do they intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application?..... Yes No
If "Yes," check the appropriate box(es) below. The Producer shall comply with any additional state and/or Company replacement requirements.

| Company | Proposed Insured | Policy or Contract Number | Face Amount | Pending? | ADB Amount | 1035 Exchange? | To Be Replaced? | Assigned or Sold? |
|---------|------------------|---------------------------|-------------|--|------------|--|--|--|
| | | | | <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 | <input type="checkbox"/> Yes <input type="checkbox"/> No |

3 If this is a replacement, have you received a copy of the Notice of Replacement (if required in your state)?..... Yes No

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SECTION D HEALTH INFORMATION

HAVE ANY OF THE PROPOSED INSUREDS RECEIVED MEDICAL CARE FOR OR HAD:

- (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 |
|---|-------------------------|---------------------------------|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| 6 | | |
| 7 | | |
| 8 | | |

SECTION E PREMIUM AND BILLING INFORMATION

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

SECTION F AGREEMENT

I am the parent, grandparent or guardian of the Proposed Insured(s) and 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).

I have read and understand this Agreement Section and any Receipt provided, and I approve all the answers as recorded in this application.

Signed at: _____ Date _____
 City State 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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Third Party Notice Request Form

You have the right to designate a person, in addition to yourself, to receive notice that your premium is past due and has not been paid. This notice will be sent at least 30 days prior to the effective date of cancellation of your policy or certificate. This notice will state the amount of premium, the date by when the premium must be paid to avoid policy cancellation and the date on which coverage terminates.

You can designate this additional person to receive notice of nonpayment now or at a later time, provided the policy is in force, and you give us written notice containing the additional person's name, address and phone number.

You have the right to change this third-party designation at any time; however, you must submit the change in writing to the address below.

PLEASE COMPLETE EITHER SECTION 1 OR SECTION 2 AND RETURN TO US.

Section 1

I wish to designate an additional person to receive notice of nonpayment of premium.

Policyowner/Certificateholder: _____

Policy Number: _____ Date: _____

Third Party: _____
(Please print name of other person to receive notice of nonpayment)

Third Party Address: _____
(Street Address) (City) (State) (ZIP)

Third Party Phone: (_____) _____
(Area Code) (Number)

Signature of Policyowner/Certificateholder

_____ Date _____

Section 2

I do not wish to designate an additional person to receive notice of nonpayment of premium.

Signature of Policyowner/Certificateholder

_____ Date _____

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



Sale or Liquidation of Assets Disclosure to Elders

California Insurance Code §789.8 requires that the following notice be given to all prospective purchasers of life insurance or annuities, age 65 or over:

The sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You or your agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold.

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GIVE THIS NOTICE TO THE APPLICANT



UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Notice Regarding Replacement Replacing Your Life Insurance Policy or Annuity?

Are you thinking about buying a new life insurance policy or an 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 company or agent 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.

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



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Applicant's/Owner's Signature

Date

Agent's Signature

