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: This cover sheet is required on every MoO application

Name of Insured
Mary L Smith

Name of Agent	Production Number	Phone Number	Email Address
Joe Agent	012345	(773) 551-5983	agentj@yahoo.com

* Next Highest Upline	Production Number	Phone Number	Email Address
Agent Upline	Not needed	Not needed	Not needed

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

L7421

UNITED OF OMAHA LIFE INSURANCE COMPANY

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

Be aware of Build chart

Application for Individual Life Ins

PROPOSED INSURED

Name (First, Middle Initial, Last)	Sex	Height	Weight	Social Security No.
Mary L Smith	☐ Male ☒ Female	5'5	150	012-34-5678

Home Address (Street, City, State, Zip)	State of Birth	Date of Birth	Age
123 Main st, Chicago, IL 60606	IL	1-1-45	70

Phone No.	E-mail	Driver's License No.	Driver's License State
773-123-4567	Not needed	DL# or State ID#	IL

Are you a legal resident of the United States? ☒ Yes ☐ No
(if "No", you are not eligible for coverage) Must be legal

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

* Complete only if owner is different than applicant

Policyowner Address (Street, City	Social Security No.

Sex	Date of Bi	Citizenship Country
☐ Male ☐ Female		

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

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)
	Be sure to take your time and read each
	question exactly as written

Select coverage that applies

PLAN INFORMATION

Plan:
☒ Level Benefit Product ☐ Graded Benefit Product
Amount Applied For $ 10,000 put face amount

Rider: (Only if selecting Level Benefit Product)
☐ Accidental Death Rider
leave blank if not applying for ADR

Payment Mode:
☐ Annual ☐ Semiannual ☐ Quarterly ☒ Monthly (Automated Bank Account Withdrawal)
Modal Premium $ 65.70 Collected Premium $ N/A only use if check is collected

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

Primary Beneficiary	Relationship to Insured	Date of Birth
John Smith	Spouse	5-5-45
Contingent Beneficiary	**Relationship to Insured**	**Date of Birth**
Jan Smith	Daughter	7-7-70

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?
New York Life	Mary L Smith	5,000	☐ Yes ☒ No
			☐ Yes ☐ No

AGREEMENT

1. The undersigned agree(s) that (a) all answers in this application are true and complete to the best of my knowledge and belief; (b) United of Omaha Life Insurance Company ("United of Omaha") will rely on these answers to determine insurability; and (c) incorrect or misleading answers may void this application and any issued policy effective the issue date.
2. The undersigned acknowledge(s) that United of Omaha may require medical records, an underwriting assessment, a medical examination, or other information.
3. The undersigned agree(s) that United of Omaha will not issue a policy as a result of this application unless (a) the Proposed Insured completes all medical examinations and tests required by United of Omaha; (b) United of Omaha receives any additional information requested for underwriting; and (c) the Proposed Insured is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the Proposed Insured or the Applicant (if other than the Proposed Insured) has subsequently accepted an offer by United of Omaha for coverage other than as applied for, according to the underwriting standards of United of Omaha then in force.
4. The undersigned agree(s) that this application does not provide temporary or interim insurance prior to policy issuance. If the undersigned has made an advance premium payment, undersigned agree(s) to the terms and conditions of the Conditional Receipt. The undersigned agree(s) that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. The undersigned acknowledge(s) that if this application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to the Proposed Insured or the Applicant (if other than the Proposed Insured), without interest. No insurance coverage will be in effect until United of Omaha (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application.
5. A completed and signed application will become part of the Proposed Insured's policy or the Applicant's policy (if other than the Proposed Insured).
6. The undersigned acknowledge(s) that no producer can (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.

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 received the MIB, Inc. Pre-Notice, the Notice of Information Practices and a Life Insurance Buyer's Guide before completing this application.

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.

I approve the answers to the questions in this application as recorded.

I have read and understand the Authorization to Receive Information form and Disclose Information to MIB, Inc. and the Agreement Section.

Signed at: Chicago (City) IL (State)

X Client Signs — Signature of Proposed Insured — Date: 01/01/2015

N/A in most cases — Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured) — Date:

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.

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

Has the Proposed Insured informed you, the Producer(s), that he/she has any pending applications or existing life insurance or annuity contracts with the company or any other company? ☒ Yes ☐ No

(If either question is answered "Yes," fulfill all state and company requirements.)

Are you related to the Proposed Insured or Owner? ☐ Yes ☒ No

If "Yes," state relationship _____

How long have you known the Proposed Insured? 1 day

How long have you known the Proposed Owner? N/A

X Agent Signs here (Signature of Producer #1)	(Producer E-mail)	your ## (Production Number)	(Date)
Only if split commissions (Signature of Producer #2)	(Producer E-mail)	(Production Number)	(Date)
Your Name Here (Print Producer #1 Name)	N/A (Print Producer #2 Name)	YIG (Agency Name)	

Producer Statement

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 I conducted said interview in person ..... ☒ Yes ☐ No

If "No," please explain _____

_____

3 List any additional information or comments below:

_____

_____

_____

_____

_____

_____

_____

UNITED OF OMAHA LIFE INSURANCE COMPANY

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

PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: Mary L Smith Policy Number(s) if known: N/A

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

PAYMENT INFORMATION

1. **Initial Monthly Premium Payment (select only one option)** Amount Quoted $ 65.70

   ☐ Draft premium immediately upon approval/issue

   ☒ Draft initial premium on or after: 2 / 3 / 15 (Please Note: If policy issue is after date selected, premium will be withdrawn on the policy issue date or receipt of delivery requirements)

   ☐ Check collected and mailed to Mutual of Omaha

   When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT AS STATED ABOVE. The first Withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. We **CANNOT** establish electronic payments from foreign banks.

2. **Ongoing Premium Payments**- Automated Bank Account Withdrawal (Monthly)
   Specify the date ongoing premiums will be withdrawn: (1st through the 28th of each month) 3rd
   Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

PAYOR INFORMATION

Name of payor as shown on bank account: Mary L Smith Social Security No. 012-34-5678

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 required)

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

ACCOUNT INFORMATION

1. Account Type (check one): ■ Checking ☐ Savings
2. Name of Financial Institution: Bank of America
3. Complete information below or attach a voided check here.
   Bank Routing Number: 012345678 (always 9 numbers) Bank Account Number: 000123456789
   (Do not use Debit/Credit Card numbers)

* get voided check if possible but not required

Memo _____ Signed By: _____

⑆123456789⑆ 123456789⑈ 1234⑈

Bank Routing Number | Bank Account Number | Check Number (if shown at bottom, may be shown before or after the account #)

AUTHORIZATION

I authorize United of Omaha Life Insurance Company ("United of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to United of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. 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 may require written confirmation from me within 14 days after my verbal notice.

Date 01/01/15 (Mo./Day/Yr.) X Owner of bank account signs here (Authorized Signature as Shown on Account)

* Payor can be different than insured

L8473_0114

MUTUAL OF OMAHA INSURANCE COMPANY
UNITED OF OMAHA LIFE INSURANCE COMPANY

Mutual of Omaha

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, MIB Inc., state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me and my children, if they are proposed insureds (My Children), to release Personal Information about me or My Children to Mutual of Omaha Insurance Company, its affiliated companies (Mutual) or its reinsurers.

The Personal Information will be used to determine my and My Children's eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

I also authorize Mutual, or its reinsurers, to disclose my and My Children's personal Information to MIB, Inc. I understand that my and My Children's Personal Information received by MIB, Inc. 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.

I understand that if the person or entity to whom Personal information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal information may be redisclosed without the protection of the federal privacy regulations.

I understand that I may refuse to sign this authorization. I understand if I refuse to sign, the insurance for which I am applying will not be issued.

This authorization will expire 24 months after the date signed. I may revoke this authorization at any time by written notice to ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. A revocation is limited to the extent that Mutual has taken action in reliance on the authorization or the law allows Mutual to contest the issuance of the policy or a claim under the policy.

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Proposed Insured acknowledges and agrees that if there is more than one Proposed Insured on this application, all information provided may be reviewed or shared with the other Proposed Insured. A completed and signed application will become part of each insured's policy.

Name(s) used for medical records (if different than the name) below: _____

X Client signs here _____ **Date:** date
Signature of Proposed Insured — Mo Day Yr

N/A _____ **Date:** _____
Signature of Spouse (if Proposed Insured) — Mo Day Yr

N/A _____ **Date:** _____
Signature of Parent or Guardian (if Proposed Insured is a Minor) — Mo Day Yr

N/A _____ **Date:** _____
Signature of Non-minor Child (if Proposed Insured is a Non-minor) — Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

L8232_0913

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: 1-1-15

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.

X Client signs here — Signature of Proposed Insured — Date: 01-01-15

N/A — Signature of Other Proposed Insured — Date

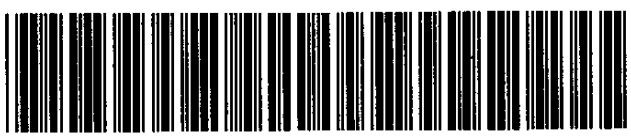
Signature of Applicant/Owner (if other than Proposed Insured) — Date

Payment Method: Check ☐ Electronic Transaction Authorization ☒ Amount remitted/authorized $ 65.70

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.

X Agent Signs — Signature of Producer — Date: 01-01-15

N/A — Signature of Producer — Date



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

Mutual of Omaha

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.

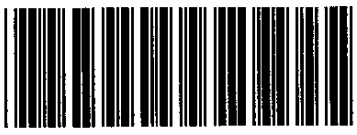
Acknowledgment

I acknowledge receipt of this disclosure form.

X Client Signs _____ 01-01-15
Applicant/Owner Signature Date

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

X Agent Signs _____ 01-01-15
Producer Signature Date



Company's Copy

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