

SAMPLE BURIAL INSURANCE APPLICATION



Application for Individual Life Insurance

PROPOSED INSURED					
Name (First, Middle Initial, Last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(Optional)- Secondary Addressee: To help make sure your policy stays in force, you can have the person listed below receive a notice when your policy is past due and has not been paid. Name _____ Address _____ Phone 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 <input type="checkbox"/> Male <input type="checkbox"/> 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? (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? (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)?					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the Proposed Insured ever been: (a) diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or been treated for AIDS or ARC by a physician or health care provider? (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? (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? (d) advised to receive or have received an organ or bone marrow transplant? (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 12months?					<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. 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 AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known? (b) diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind? . .					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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)?					<input type="checkbox"/> Yes <input type="checkbox"/> 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.	
<p>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:</p> <p>(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)?</p> <p>(b) Hepatitis C?</p> <p>(c) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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:</p> <p>(a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)? ...</p> <p>(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?</p> <p>(c) Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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:</p> <p>(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement?</p> <p>(b) Stroke or Transient Ischemic Attack (TIA)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. In the past 2 years, has the Proposed Insured:</p> <p>(a) been convicted of, incarcerated for or currently awaiting trial for a felony?</p> <p>(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?</p> <p>(c) used unlawful drugs in any form or abused or misused prescription drugs?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>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?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>10. In the past 12 months, has the Proposed Insured consulted a physician for chronic cough, <u>unexplained</u> weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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:
 Level Benefit Product Graded Benefit Product

Amount Applied For \$ _____

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

- Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company? Yes No
- 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?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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: I represent the information above is true and complete, to the best of my knowledge and belief. 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.

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PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: _____ Policy Number(s) if known: _____

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

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

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

Deduct premium immediately upon approval/issue

Deduct initial premium on or after: ____/____/____ (Please Note: If the policy issue is after the date selected, the initial payment will be deducted on the date the policy is issued or all delivery requirements are received.)

Check collected and mailed to Mutual of Omaha

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

PAYMENT INFORMATION FOR ONGOING PAYMENTS- AUTOMATIC BANK ACCOUNT DEDUCTION

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

Choose the day payments will be deducted every month from your bank account:
(1st through the 28th or Last Day of every month) _____

-OR-

Choose the week and weekday that payments will be deducted every month from your bank account:
(For example, 3rd Wednesday of every month)

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

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

PAYOR INFORMATION

Name of payor as shown on bank account: _____

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

Employer Living Trust

Business owned by Proposed Insured/Insured or spouse Other _____

Power of Attorney or legal guardian

PAYOR ACCOUNT INFORMATION

1. Account Type (check one): Checking Savings

2. Name of Financial Institution: _____

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

Bank Routing Number: _____ Bank Account Number: _____
(Do not use Debit/Credit Card numbers)

Memo _____	Signed By: _____	
Bank Routing Number	Bank Account Number	Check Number (if shown at bottom, may be shown before or after the account #)

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