Application for Group Life Insurance

United of Omaha Life Insurance Company (United)
Home Office: Omaha, Nebraska
Please Return the Attached Form to the Attention of: S1 - Group Underwriting Individual Selection
(Please complete in black ink.)

Section 1 - To Be Completed By Employer

Employer's name ____________________

Employer's address ____________________

Group No. ____________ Date employee's full-time employment began ____________

Employees job description ____________________

Signed for employer by ____________ Employer phone number: ____________

Section 2 - To Be Completed By You

Name ____________________ Soc. Sec. No. ____________
(Last) (First) (Middle)

Address ____________________
(Street) (City) (State) (Zip Code)

Date of Birth ________ Place of birth ____________ Height ______ Weight ______ Sex ________
(Mo.) (Day) (Yr.) (Include State if Born in U.S.)

Beneficiary ____________________Applicant's Phone # ____________

For You Only
Total amount of insurance being applied for is $ ____________ My annual Salary is $ ____________

For Your Spouse
Total amount of insurance being applied for is $ ____________

For Your Dependent Children
Total amount of insurance being applied for is $ ____________

If you apply for dependents insurance, list all your eligible dependents below. Include your spouse and all unmarried children.

Name of Dependents	Relationship	Birth Date	Height	Weight

Statement of Physical Condition
If you answer "Yes" to any of the following questions, please give full details following question 3 below. YES NO

1. During the past ten years, have you or your dependents ever had, been told of having, or received advice or treatment for any of the following: blood or circulatory disorder, mental nervous or emotional disorder, kidney disorder, lung disorder, heart disorder, liver disorder, diabetes, alcohol or drug abuse, paralysis, cancer, tumor, epilepsy, high blood pressure, stroke, or having Acquired Immune Deficiency Syndrome (AIDS)? ………… ☐ ☐
2. During the past five years, have you or your dependents had prescribed or taken any drug requiring a physician's prescription? ………… ☐ ☐
3. During the past five years, have you or your dependents ever been confined to any hospital or similar institution, or consulted a physician for any disease not listed above, or been advised to have any surgical operation or diagnostic tests?………… ☐ ☐

For any "Yes" answers above, please complete the following.

Ques. No.	Name	Condition, Injury, findings of Examination, or prescription	Month and Year	Date of Recovery	Name and Address of Hospital or Attending Physician

Please sign and date on the reverse side

STATEMENT OF APPLICATION AND AUTHORIZATION

I apply for life insurance for myself and those dependents named above who are eligible for insurance. I understand that any insurance for myself and/or my dependent spouse in excess of the guaranteed issue amounts will not begin until United of Omaha approves my spouse and myself for such amounts. I have given the above answers to obtain this insurance. Information in this application, a copy of which shall be attached to and made a part of my certificate when issued, is given to obtain the program requested and is true and complete to the best of my knowledge and belief. I know that insurance could be void if these answers are not true and complete.
I permit my employer to deduct the monthly premium contribution from my earnings.
Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an applicant or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Authorization to Receive and Disclose Information

Meanings of Terms

"MIB Group, Inc. (MIB)" means: a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also.

To the MIB:

I authorize you to disclose Personal Information about me, (the undersigned), or my children, to United of Omaha Life Insurance Company and its reinsurers. You are not authorized to disclose information about me to a consumer reporting agency. Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance with United of Omaha Life Insurance.

I also authorize United of Omaha Life Insurance Company and its reinsurers to disclose Personal Information about me or my children to the MIB. I understand that the Personal Information received by the 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.

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

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I signed it. I understand that I may revoke this authorization at any time, by written notice to:

Attn: Group Specialty Underwriting
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I also understand that any revocation of this authorization will not affect any use or disclosure of Personal Information that occurred prior to the receipt of my revocation.

I have been advised that I, or my authorized representative, am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.

Name(s) used for medical records (if different than the names(s) below):____

____ ____________________________
Signature of Employee Date

____ ____________________________
Signature of Spouse Date