NEW BUSINESS MEMO
WHOLE LIFE

Regular Mail:
United Home Life Insurance Company
P.O. Box 7192
Indianapolis, IN 46207-7192

FAX Number: 317-692-7711
Telephone: 800-428-3001

Overnight Mail:
United Home Life Insurance Company
225 South East St
Indianapolis, IN 46202

_____ # pages including cover

Agt Name: _____ Agt # _____

Agt Phone: _____ Agt Fax: _____

Agt Email Address: _____@_____._____

How do you prefer to be notified if we should need any underwriting requirements?
☐ E-Mail ☐ Fax ☐ US Mail

Street _____ City _____ State _____ Zip Code_____

Did you personally see all persons proposed for insurance and personally view a photo ID (driver's license, passport) of the proposed owner and/or insured? ☐ Yes ☐ No
If No, how was the application taken? Solicited by: ☐ Mail ☐ Telephone ☐ Internet
☐ Fax or Other _____
Did you identify any unusual behavior or suspicious activity by the proposed owner or insured? ☐ Yes ☐ No
If Yes, please explain. _____

Personal History Interviews (PHIs): You have two options:

Option 1 (preferred option) Know Before You Go: You, the agent, initiate a point-of-sale (POS) interview from your client's home by calling **866-333-6557**. Tell the operator this interview is for UHL and the Total Protection Series EIWL (graded benefit), Deluxe or Premier plan and hand the phone to your client **(Be specific as to which product you want so that only the plan specific questions will be asked).** During the **call**, the interviewer will conduct MIB and Prescription Drug searches to better determine your client's suitability for the product you've selected. Upon completion of the interview and based on the client's answers to the questions and results of the database searches, the interviewer will tell you whether or not the application should be sent to the Home Office.

Option 2: UHL will order the PHI after you've completed the application with your client. This option requires a PHI for all Total Protection Series EIWL Deluxe and Premier sales, regardless of face amount. What is the best time to reach this client?

Home Phone (_____) _____available days? ☐ Yes ☐ No
Business Phone (_____) _____available days? ☐ Yes ☐ No
Cell Phone (_____) _____available days? ☐ Yes ☐ No

If a language other than English is required, please specify below.

Did you complete a Point of Sale Personal History Interview with your client? ☐ Yes ☐ No

Special Instructions you want us to know: _____
_____
_____

Application Completion "Tips"

1. Make sure to use the app with the correct state variations
2. If Child Rider is requested, submit application 200-359
3. If the first premium is going to be drafted from the client's bank account, *provide a copy of a pre-printed voided check!* Otherwise, the case will be unnecessarily delayed
4. Print legibly in English
5. Keep original app until policy is issued
6. Keep fax confirmation message that fax was successful

MAIL POLICY TO: ☐ Applicant ☐ Agent

Whole Life Insurance Application

United Home Life Insurance Company • 225 S. East St. • P.O. Box 7192 • Indianapolis, IN 46207-7192 • 1-800-428-3001

1. Last Name	First Name	Middle Initial	Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female
Marital Status	Height	Weight	Social Security Number	U.S. Citizen: ❑ Yes ❑ No *If no, give immigration status/type of visa:*	
Street Address	City	State	Zip Code	Phone Number ( )	

2. Employer/Occupation/Duties/How Long There

3.a. Primary Beneficiary Name	Relationship	Age
3.b. Contingent Beneficiary Name	Relationship	Age

4.a. Owner Name	Relationship	Social Security Number
Owner Street Address	City	State / Zip Code
4.b. Contingent Owner Name	Relationship	Social Security Number

5. Billing Street Address	City	State	Zip Code
Secondary Addressee (For Past Due Notice) / Name	Street	City	State / Zip Code

6.a. Plan of Insurance ❑ Express Issue Whole Life ❑ Express Issue Deluxe ❑ Express Issue Premier **6.b.** Face Amount: $_____

6.c. If the Face Amount shown above is $10,000 or greater and the product applied for is the Express Issue Whole Life, the following riders will be attached to the policy: Identity Theft Waiver of Premium Rider, Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

6.d. ❑ Accidental Death Benefit (not available with Express Issue WL) $

6.e. Modal Premium: ❑ Annual ❑ Semi-Annual ❑ Qtrly. ❑ PAC
Modal Premium Amount $

7. Will this insurance replace or change any other insurance policies or annuities? ❑ Yes ❑ No If "Yes," please complete any necessary replacement forms.

8. Has the proposed insured used nicotine in any form in the past 12 months? ❑ Yes ❑ No

9. Name and Address of Family Physician (Required) | Family Physician Telephone Number (Required) ( ) -

SECTION I - EXPRESS ISSUE WHOLE LIFE – COMPLETE SECTION I ONLY

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been diagnosed by a licensed member of the medical profession as needing an organ transplant or have you been diagnosed by a licensed member of the medical profession as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)	❑ Yes ❑ No
B. Do you require assistance to feed, bathe, dress or take your own medication or are you currently confined to a hospital, nursing home, medical related facility or require home health care?	❑ Yes ❑ No
C. Has the proposed insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	❑ Yes ❑ No
D. **In the past twelve (12) months:**	
1. Other than for temporary or minor conditions, have you been confined to a hospital two or more times?	❑ Yes ❑ No
2. Other than preventive, maintenance or risk lowering medications prescribed, have you been treated for or diagnosed by a licensed member of the medical profession with any cancer (other than Basal Cell skin cancer), heart attack, stroke, or had heart surgery (including angioplasty)?	❑ Yes ❑ No
3. Have you used any illegal drugs, been treated by a licensed member of the medical profession for or advised to have treatment by a licensed member of the medical profession for drug abuse?	❑ Yes ❑ No

If any question in Section I is answered "Yes", you are not eligible for any plan of insurance.

SECTION II - EXPRESS ISSUE DELUXE – COMPLETE SECTIONS I & II ONLY

A. **In the past 5 years:**	
1. Have you been diagnosed or treated by a licensed member of the medical profession for, or are you currently under treatment by a licensed member of the medical profession for:	
a. Alzheimer's Disease or Dementia?	❑ Yes ❑ No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	❑ Yes ❑ No
c. Other than preventive, maintenance or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension (controlled hypertension means blood pressure, regardless of treatment, has not exceeded 170/100)) or Stroke?	❑ Yes ❑ No

d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	❑ Yes ❑ No
e. Sickle Cell Anemia or Kidney Disease (including dialysis) or Liver Disease (including hepatitis B & C)?	❑ Yes ❑ No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	❑ Yes ❑ No
g. ALS (Lou Gehrig's Disease) or Neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years)?	❑ Yes ❑ No
2. Have you been advised by a licensed member of the medical profession to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	❑ Yes ❑ No
3. Have you been treated by a licensed member of the medical profession for or been advised to have treatment by a licensed member of the medical profession for alcohol or drug dependency or consumed more than 10 alcoholic drinks per day?	❑ Yes ❑ No
B. **In the past 2 years** have you been declined or postponed for Life or Health Insurance?	❑ Yes ❑ No
C. **In the past 10 years** have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	❑ Yes ❑ No
D. If under age 65, are you currently disabled, or been disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	❑ Yes ❑ No
If any question in Section II is answered "Yes", you are not eligible for Express Issue Deluxe. Submit the case as Express Issue Whole Life.	

SECTION III - EXPRESS ISSUE PREMIER – COMPLETE SECTIONS I, II & III

A. **In the past 5 years**:	
1. Have you been diagnosed or treated by a licensed member of the medical profession for, or are you currently under treatment by a licensed member of the medical profession for:	
a. Schizophrenia or Bipolar Disorder?	❑ Yes ❑ No
b. Diabetes requiring insulin treatment?	❑ Yes ❑ No
c. SLE (Systemic Lupus Erythematosus)?	❑ Yes ❑ No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	❑ Yes ❑ No
B. Do you now participate in, or do you have plans within the next 2 years to participate in scuba diving, sky diving, hang-gliding, mountain climbing, rock climbing, any form of motorized racing or any type of flying as a pilot or crew member?	❑ Yes ❑ No
If any question in Section III is answered "Yes", you are not eligible for Express Issue Premier. Submit the case as Express Issue Deluxe.	

I hereby apply for the insurance indicated above and I am submitting the first premium. I certify that the answers are true and accurate whether written by my own hand or not. I understand that my policy will not be effective until the date it is issued by the company.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release to United Home Life Insurance Company medical information which may include treatment of physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information. United Home Life Insurance Company may not disclose HIV, AIDS, or AIDS-related information outside of the insurance company or its employees, insurance affiliates, agents, or reinsurers, except to me and the persons I have designated in writing.

I understand that United Home Life Insurance Company may require I submit to an HIV Screen. The HIV screen will be one recommended by the Centers for Disease Control and Prevention or by the federal Food and Drug Administration. Prior to testing I must be provided and sign a separate Notice and Consent for Blood Fluid and Other Bodily Fluid Testing which may include AIDS Virus Antibody Testing form.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose for up to two (2) years from the date the contract is issued.

WARNING

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

$_____ paid with application.

Dated _____ (City) _____ (State) , this _____ day of _____ (Month) , _____ (Year)

X _____ Signature of Owner (if other than Proposed Insured) **X** _____ Signature of Proposed Insured

To the best of my knowledge and belief the insurance applied for herein is ☐ is not ☐ intended to replace or change any existing life insurance or annuity coverage.

X _____ Printed Agent Name **X** _____ Agent's Signature

Agent Code _____ Agent's E-Mail _____

Agent: Phone # _____ Fax# _____ License Identification Number (_____) _____ State

Check or money order must accompany. All premium checks must be made payable to United Home Life Insurance Company. Do not make check or money order payable to the agent or leave the Payee blank. Include copy of voided check for bank draft.

AUTHORIZATION TO HONOR CHECKS DRAWN BY THE UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana

Please select ONLY one option, complete bank information and sign authorization below.

☐ Draft my account for the first premium (initial premium may be drafted upon receipt of this application). Please draft subsequent premiums on the _____ day of each month.

☐ Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day each month.
Month, Day

☐ Do NOT draft my account for the first premium. The initial premium is attached, is being mailed or will be collected on delivery. Please draft subsequent premiums on the _____ day of each month.

I understand that my policy will not be effective until the date it is issued by the company.

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

TO: _____ Bank _____Bank Address

As a convenience to me, I hereby request and authorize you to pay and charge to my account debit entries drawn on my account by and payable to the order of the United Home Life Insurance Company, Indianapolis, Indiana, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit entry shall be the same as if it were a debit entry drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit entry.

I further agree that if any such debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Account No. _____ Date_____ Bank signature of Premium Payor _____

PLEASE DETACH AND GIVE TO APPLICANT

If you do not receive your Policy within 60 days from the date of your application, please write to **UNITED HOME LIFE INSURANCE COMPANY, P.O. Box 7192, Indianapolis, Indiana 46207-7192**

UNITED HOME LIFE INSURANCE COMPANY, Indianapolis, Indiana (Herein referred to as the Company)

All premium checks must be made payable to United Home Life Insurance Company. Do not make check payable to the agent or leave payee blank.

I understand that my policy will not be effective until the date it is issued by the company.

RECEIPT

Received from _____ The sum of $ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance $ _____

This receipt shall be void if given for check or draft which is not honored on presentation.

Dated at _____ on _____ , _____
Month Day Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MIB, INC., NOTICE

In compliance with the provisions of the FAIR CREDIT REPORTING ACT, this notice is to inform you that in connection with your application for insurance an investigative consumer report may be prepared. Such a report includes information as to the consumer's character, general reputation, personal characteristics, and mode of living and is obtained through personal interviews with friends, neighbors, and associates of the consumer. Upon written request, a complete and accurate disclosure of the nature and scope of the report, if one is made, will be provided.

Information regarding your insurability will be treated as confidential. Such report will not include any HIV, AIDS or AIDS-related information. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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 office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted, with the exception of HIV, AIDS or AIDS-related information. Information for consumers about MIB may be obtained on its website at www.mib.com.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Authorization for Release of Medical Information

United Home Life Insurance Company
P.O. Box 7192, Indianapolis IN 46207-7192

This authorization complies with the HIPAA Privacy Rule.

_____ _____ / _____ / _____

Name of proposed insured/patient **(please type or print)** Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that United Home Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with United Home Life Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: United Home Life Insurance Company at P.O. Box 7192, Indianapolis IN 46207-7192, Attention: Director, Life Underwriting. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that United Home Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, United Home Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Authorization for Release of Medical Information

United Home Life Insurance Company
P.O. Box 7192, Indianapolis IN 46207-7192

This authorization complies with the HIPAA Privacy Rule.

_____ _____ / _____ / _____

Name of proposed insured/patient **(please type or print)** Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Home Life Insurance Company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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Description of Personal Representative's Authority or Relationship to Patient