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: _____

_____

_____

Name of Insured

Name of Agent	Production Number	Phone Number	Email Address

Next Highest Upline	Production Number	Phone Number	Email Address

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

_____

_____

_____

_____

_____

_____

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

FLORIDA – APPLICATION FOR LIFE INSURANCE

FULLY UNDERWRITTEN PRODUCTS – One Base Policy Per Application

Checklist for Submitting a Complete 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

PRODUCTS	OPTIONAL RIDERS
❑ Term Life Answers (TLA)	❑ Disability Waiver of Premium Rider ❑ Other Insured Rider ❑ Dependent Children's Rider ($1,000 - $10,000) ❑ Accidental Death Benefits Rider
❑ Guaranteed Universal Life (GUL) ❑ AccumUL Plus ❑ AccumUL Answers ❑ Income Advantage (IUL) ❑ Life Protection Advantage (IUL)	❑ Disability Waiver of Policy Charges ❑ Disability Continuation of Planned Premium Rider ❑ Guaranteed Insurability Rider ($10,000-$50,000) ❑ Dependent Children's Rider ($1,000 - $10,000) ❑ Accidental Death Benefit Rider ❑ Additional Insured Term Rider - Self & Other Insured (AccumUL Plus, AccumUL Answers, Income Advantage & Life Protection Advantage only) ❑ Long-Term Care Benefits Rider (Income Advantage & Life Protecction Advantage Only)

APPLICATION SUBMISSION GUIDELINES

- ❑ Attach a cover letter or additional information as needed, **AND** Always submit the Producer Statement and Producer Report page
- ❑ Always obtain signed HIPAA/MIB authorization
- ❑ Leave all applicable forms and Life Insurance Buyer's Guide with the Proposed Insured
- ❑ All changes should be initialed by the Applicant/Owner
- ❑ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client
- ❑ If selecting the Disability Continuation of Planned Premium Rider, Accidental Death Benefit Rider, Dependent Children's Rider, Additional Insured Term Rider or the Other Insured Rider, a **RIDER AMOUNT** must be entered on the application.

IMPORTANT FORMS

- ❑ Replacement Notice – If applicable, the client must sign and retain a copy for their records
- ❑ Payment Authorization – Complete this form if applicable
- ❑ Complete two copies of the TIA form and leave the unsigned copy with the applicant when: a) all 6 questions on the TIA are answered "no"; and b) a check or electronic transaction authorization for the initial premium is collected. **DO NOT** collect a check if any of the 6 TIA questions are answered "yes" - a completed electronic transaction authorization may still be submitted. **DO NOT** complete the TIA if initial payment won't be collected until issue.
- ❑ You will need a signed Accelerated Death Benefit Rider Disclosure Form
- ❑ If face amount is $100,000 or over, you will need a signed HIV consent form (If your state does not require the HIV Consent form, then this form will not be included in this application package)
- ❑ If face amount is $1,000,000 and above and the Proposed Insured is age 65, or over you will need: (a) signed Statement of Policyowner form and, (b) signed Premium Funding and Acknowledgement form
- ❑ Federal Form F4506T-EZ - Used to request tax records for the insured. This form is required for applications with a face amount of greater than $5 million and may be requested by underwriting as necessary.
- ❑ Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor - Complete this form if applicable. The client must sign and retain a copy for their records.

SUPPLEMENTAL APPLICATIONS, FORMS & BUYER'S GUIDE

- ● ***Child(s) Rider Supplemental Application:*** Complete if applying for the Children's Rider
- ● ***Juvenile Life Insurance Supplemental Application:*** Complete if applying for life insurance for proposed insured ages 0-17 years
- ● ***Long-Term Care Benefits Rider Supplemental Application Packet:*** Complete if applying for the Long-Term Care Rider
- ● ***Indexed Universal Life Premium Allocation form:*** Complete if applying for Income Advantage or LIfe Protection Advantage
- ● ***Acknowledgment/Illustration Certification form:*** If applicable, required when no illustration was used at point of sale, or the policy applied for is other than as shown in the illustration, or a computer screen illustration was displayed at point of sale but no hard copy was furnished
- ● ***1035 Exchange:*** By exercising a 1035 (a) exchange, the client may transfer the money from the old carrier to United of Omaha without incurring a taxable gain for federal income tax purposes
- ● ***Buyer's Guide:*** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale

PARAMEDICAL VENDORS	INDICATE UNDERWRITING REQUIREMENTS INITIATED OR COMPLETED ON THE PROPOSED INSURED(S)	
APPS – 1-800-635-1677 **EMSI** – 1-800-872-3674 **EXAMONE** – 1-877-933-9261	**Primary Proposed Insured** ☐ Blood Profile ☐ Urinalysis ☐ Physical Data ☐ MD Exam ☐ Long Form Exam ☐ EKG ☐ Treadmill EKG	**Other Proposed Insured:** ☐ Blood Profile ☐ Urinalysis ☐ Physical Data ☐ MD Exam ☐ Long Form Exam ☐ EKG ☐ Treadmill EKG

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company
3300 Mutual of Omaha Plaza, Omaha, NE 68175

INDIVIDUAL LIFE INSURANCE APPLICATION PART 1, PAGE 1 OF 5

Proposed Insured (If Proposed Insured is age 0-17, complete the Juvenile Supplemental Application)			
Name (First, Middle Initial, Last)		Social Security Number	Gender at Birth ☐ Male ☐ Female
Home Address (Street, City, State, ZIP)			Marital Status
Primary Phone No.	Secondary Phone No.	E-mail(may be used for delivery of policy)	
Driver's License No. (If none, please explain)			Driver's License State
Occupation/Duties		Annual Income	Employer
Date of Birth	State of Birth (Country if not U.S.)	U.S. Citizen?....☐**Yes** ☐**No** **(If No, complete the Foreign National and Foreign Travel questionnaire)**	
Have you ever used any form of tobacco or any form of nicotine replacement therapy?..☐**Yes** ☐**No** Date Stopped_____ month/year **(If Yes, provide details in the Comments section.)**			

Proposed Insured Beneficiary (If more space is needed, use the Comments section)			
Primary Beneficiary	% of Proceeds	Date of Birth	Relationship to Proposed Insured
Contingent Beneficiary	% of Proceeds	Date of Birth	Relationship to Proposed Insured

Other Proposed Insured (If Other Proposed Insured is age 0-17, complete the Juvenile Supplemental Application)			
Name (First, Middle Initial, Last)		Social Security Number	Gender at Birth ☐ Male ☐ Female
Home Address (Street, City, State, ZIP)			Relationship to Proposed Insured
Primary Phone No.	Secondary Phone No.	E-mail	
Driver's License No. (If none, please explain)			Driver's License State
Occupation/Duties		Annual Income	Employer
Date of Birth	State of Birth (Country if not U.S.)	U.S. Citizen?....☐**Yes** ☐**No** **(If No, complete the Foreign National and Foreign Travel questionnaire)**	
Have you ever used any form of tobacco or any form of nicotine replacement therapy?..☐**Yes** ☐**No** Date Stopped_____ month/year **(If Yes, provide details in the Comments section.)**			

Other Proposed Insured Beneficiary (If more space is needed, use the Comments section)			
Primary Beneficiary	% of Proceeds	Date of Birth	Relationship to Insured
Contingent Beneficiary	% of Proceeds	Date of Birth	Relationship to Insured

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OWNER (Complete Policyowner Information if Proposed Insured is not the Policyowner)

Owner Is: ☐ Individual ☐ Employer ☐ Trust ☐ Other (Specify): _____

Name of Policyowner (First, Middle Initial, Last)	Relationship to Proposed Insured	Social Security No./Tax ID

Policyowner Address (Street, City, State, ZIP)	Date of Birth/Date of Trust

Policyowner Phone No.	Policyowner E-mail

Secondary Addressee - Optional. This person will receive copies of overdue premium and lapse notices.

Name_____

Address_____
Street City State ZIP

PLAN INFORMATION

RISK/RATE CLASS APPLIED FOR:

☐ Standard or Best Available Risk Class
☐ Substandard Risk Class Proposed: Table _____

TERM LIFE PLAN AMOUNT OF INSURANCE APPLIED FOR: $_____

Product Selection	Optional Riders
☐ Term Life Answers (TLA) 10-Year Term Life ☐ Term Life Answers (TLA) 15-Year Term Life ☐ Term Life Answers (TLA) 20-Year Term Life ☐ Term Life Answers (TLA) 30-Year Term Life	☐ Disability Waiver of Premium ☐ Other Insured Rider: $_____ ☐ Dependent Children's Rider: $_____ ☐ Accidental Death Benefit Rider: $_____

✳ **UNIVERSAL LIFE PLAN AMOUNT OF INSURANCE APPLIED FOR: $** ✳ complete for UL products

Product Selection	Death Benefit (pick one)	Optional Riders
☐ Income Advantage (IUL) ☐ Life Protection Advantage (IUL)	☐ UL Option 1 Level Death Benefit ☐ UL Option 2 Specified Amount plus Accumulation Value	☐ Disability Waiver of Policy Charges ☐ Disability Continuation of Planned Premium Rider: $_____ ☐ Guaranteed Insurability Rider: $_____ ☐ Dependent Children's Rider: $_____ ☐ Accidental Death Benefit Rider: $_____ ☐ Additional Insured Term Rider (Self): $_____ ☐ Additional Insured Term Rider (Other Insured): $_____ ☐ Long-Term Care Benefits Rider
☐ AccumUL Plus ☐ AccumUL Answers	☐ UL Option 1 Level Death Benefit ☐ UL Option 2 Specified Amount plus Accumulation Value	☐ Disability Waiver of Policy Charges ☐ Disability Continuation of Planned Premium Rider: $_____ ☐ Guaranteed Insurability Rider: $_____ ☐ Dependent Children's Rider: $_____ ☐ Accidental Death Benefit Rider: $_____ ☐ Additional Insured Term Rider (Self): $_____ ☐ Additional Insured Term Rider (Other Insured): $_____
☐ Guaranteed Universal Life (GUL)	UL Option 1 Level Death Benefit	☐ Disability Waiver of Policy Charges ☐ Disability Continuation of Planned Premium Rider: $_____ ☐ Guaranteed Insurability Rider: $_____ ☐ Dependent Children's Rider:$_____ ☐ Accidental Death Benefit Rider: $_____

PREMIUM INFORMATION

Premium Method	☐ Direct Bill ☐ Bank Draft *(Monthly Only) (Complete Payment Authorization Form)* ☐ Other *(Please Explain)* _____
Frequency of Modal Premium	☐ Monthly *(Bank Draft Only)* ☐ Annual ☐ Semi-Annual ☐ Quarterly
Modal Premium $_____	**Proposed Insured** / **Other Proposed Insured**
Collected Premium $_____	Date Policy to Save Age? . . . . . ☐ **Yes** ☐ **No** / ☐ **Yes** ☐ **No**

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Insurance History

1. Have you been offered cash, or any other consideration for obtaining this policy? . . . . . ☐ Yes ☐ No
2. Are you planning to enter into a finance arrangement to pay any premium payments due under this policy? . . . . ☐ Yes ☐ No
3. Do you intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? . . . . . ☐ Yes ☐ No
   (If Yes to questions 1, 2 or 3, provide information in Comments section.)
4. In the past 12 months, have you applied for any life insurance or do you have any life insurance currently pending, excluding this application? . . . . . ☐ Yes ☐ No
5. Do you have any existing life insurance or annuity contracts with the company or any other company? . . . . . ☐ Yes ☐ No
6. Will this insurance replace or change any existing life insurance or annuity contract with the company or any other company? . . . . . ☐ Yes ☐ No
   (If Yes to questions 4, 5 or 6, complete the boxes below.)
   The Producer shall comply with any additional state, and/or Company replacement requirements.

Person Proposed for Insurance	Company	Face Amount	Replaced/ Converted?	Pending?	1035 Exchange?	Business or Personal	Year Issued
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		
			☐Yes ☐No	☐Yes ☐No	☐Yes ☐No		

Proposed Insured(s) History

1. Have you: (If answered Yes, please list details in the Comments section.)	Proposed Insured	Other Proposed Insured
(a) had life insurance coverage declined, postponed or limited, or been denied reinstatement or asked to pay extra premium by any insurance company?	☐ Yes ☐ No	☐ Yes ☐ No
(b) engaged in parachuting, hang gliding, rock or mountain climbing, skydiving, SCUBA diving, cliff diving, organized vehicle or boat racing, BASE or bungee jumping within the last three years or plan such activity in the next two years? **(If Yes, complete the appropriate questionnaire.)**	☐ Yes ☐ No	☐ Yes ☐ No
(c) any intention of traveling or living outside the USA or Canada in the next two years? **(If Yes, complete the Foreign National and Foreign Travel questionnaire.)**	☐ Yes ☐ No	☐ Yes ☐ No
(d) flown as a civilian pilot, student pilot or crew member within the last three years or plan such activity in the next two years? **(If Yes, complete the Aviation questionnaire.)**	☐ Yes ☐ No	☐ Yes ☐ No
(e) within the last five years been convicted of two or more moving violations, been convicted of driving under the influence of alcohol or drugs or had a driver's license suspended or revoked?	☐ Yes ☐ No	☐ Yes ☐ No
(f) been convicted of a felony or have been incarcerated within the last 10 years?	☐ Yes ☐ No	☐ Yes ☐ No
(g) been on probation within the last 12 months or are currently on probation?	☐ Yes ☐ No	☐ Yes ☐ No

Comments

Provide any additional information necessary and the details of Yes answers. Identify the question number if applicable. Use an additional sheet of paper if necessary.

FINANCES (COMPLETE EITHER THE PERSONAL OR BUSINESS SECTION)

Personal:

1. Purpose of Insurance:
   ☐ Income Replacement ☐ Debt Repayment ☐ Estate Conservation ☐ Other (Specify): _____
2. Personal Finances: Gross Annual Income $_____ Total Assets $ _____ Total Liabilities $ _____
3. Within the past 5 years, have you filed for bankruptcy or had any judgments or liens filed against you? . . ☐ **Yes** ☐ **No**
   If Yes, please explain and provide the filing and discharge dates_____

Business: Please attach a copy of your Company's latest financial statements (Balance Sheet and Profit and Loss). If not available, complete the following questions:

1. Purpose of Insurance:
   ☐ Buy-Sell: Type of Agreement: ☐ Entity/Stock Redemption ☐ Cross Purchase ☐ Wait-and-See
   ☐ Key Person: Explanation of special skills/relationships to the business _____
   _____
   ☐ Other: Please Explain_____
2. Proposed Insured's Salary (include bonus) $_____
3. Company Book Value $_____ Company Market Value $_____
   Proposed Insured's % Ownership $_____Market Value of Proposed Insured's Ownership $_____
4. Business Insurance Carried by Other Owners, Officers, Partners or Key Persons:

Name	Title and Interest	Amounts Now Carried and Company	Amount Now Applied For and Company

5. Within the past 5 years, has the business filed for bankruptcy or had any judgments or liens filed against it? . . ☐ **Yes** ☐ **No**
   If Yes, please explain and provide filing and discharge dates_____

AGREEMENT

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 temporary insurance agreement, 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.

This application includes Part 1, Part 2 and/or the Statements to Examiner as well as all approved supplemental forms or amendments the Insurer specifically designates as parts of the application, by attaching as part of any policy delivered to the Owner.

---- continued on next page ----

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Agreement Continued

Fraud Warning: Any person who knowingly and wih 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.

Signed at: _____ _____ Date _____
City State Mo Day Yr

_____
Signature of Proposed Insured Age 15 and Over

_____
Signature of Applicant/Owner/Trustee if other than Proposed Insured **or** if the Owner is a corporation, trust, or other entity. Include title of Signee(s).

_____
Signature of Other Proposed Insured Age 15 and Over

_____
Signature of Applicant/Owner/Trustee if other than Other Proposed Insured **or** if the Owner is a corporation, trust, or other entity. Include title of Signee(s).

_____
Signature of Parent or Guardian if Proposed Insured is under Age 15

_____ _____
Printed Name of Agent #1 Florida License Number

_____ ☐☐☐☐☐☐ _____
Signature of Agent #1 Production Number Date

_____ _____
Printed Name of Agent #2 Florida License Number

_____ ☐☐☐☐☐☐ _____
Signature of Agent #2 Production Number Date

_____ _____ Family First Life
Print or Stamp Agent #1 Name Print or Stamp Agent #2 Name Agency Name

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UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY
3300 Mutual of Omaha Plaza, Omaha, NE 68175

INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 1 OF 3

PROPOSED INSURED(S) INFORMATION

Name of Proposed Insured_____	Name of Other Proposed Insured_____
Date of Birth_____	Date of Birth_____
Height _____ft. _____in. Weight _____lbs.	Height _____ft. _____in. Weight _____lbs.

PHYSICIAN INFORMATION

Person Proposed for Insurance	Name, Address and Telephone Number of Personal Physician	Date Last Seen	State Reason, Findings and Treatment
	* client MUST list Doctor		

FAMILY HISTORY

	Proposed Insured	Other Proposed Insured
To the best of your knowledge and belief, do you have a deceased parent(s) and/or sibling(s)? . . (If Yes, please list details below. If more space is needed, use the Comments section.)	☐ Yes ☐ No	☐ Yes ☐ No

	Age at Death Proposed Insured	Cause of Death Proposed Insured	Age at Death Other Proposed Insured	Cause of Death Other Proposed Insured
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				

MEDICAL HISTORY

	Proposed Insured	Other Proposed Insured
1. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:		
(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, pacemaker or defibrillator, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke?	☐ Yes ☐ No	☐ Yes ☐ No
(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, sleep apnea or shortness of breath?	☐ Yes ☐ No	☐ Yes ☐ No
(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries?	☐ Yes ☐ No	☐ Yes ☐ No
(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	☐ Yes ☐ No	☐ Yes ☐ No
(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
(g) any disease, or disorder of vision, or hearing?	☐ Yes ☐ No	☐ Yes ☐ No
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/ metabolic disorder?	☐ Yes ☐ No	☐ Yes ☐ No

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Medical History Continued

	Proposed Insured	Other Proposed Insured
3. In the past 10 years, have you:		
(a) used alcohol to a degree that required treatment, or been advised by a member of the medical profession to limit, or discontinue its use?	☐ Yes ☐ No	☐ Yes ☐ No
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	☐ Yes ☐ No	☐ Yes ☐ No
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous?	☐ Yes ☐ No	☐ Yes ☐ No
4. In the past 12 months, have you:		
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?	☐ Yes ☐ No	☐ Yes ☐ No
(b) received, or been advised by a member of the medical profession to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy?	☐ Yes ☐ No	☐ Yes ☐ No
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	☐ Yes ☐ No	☐ Yes ☐ No
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?	☐ Yes ☐ No	☐ Yes ☐ No
(e) had an unexplained weight loss of greater than 10 pounds (other than due to diet or exercise)?	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past two years, have you (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? **(If Yes, please list details below. If more space is needed use the Comments section.)**	☐ Yes ☐ No	☐ Yes ☐ No

Person Proposed for Insurance	Medication Name (copy from pharmacy label)	Date Last Taken	Prescribing Physician (if any)	Reason	Dosage/ Frequency

	Proposed Insured	Other Proposed Insured
6. In the past five years, have you consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? **(If Yes, please list details below. If more space is needed use the Comments section.)**	☐ Yes ☐ No	☐ Yes ☐ No

Person Proposed for Insurance	Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

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FULLY 18B

INDIVIDUAL LIFE INSURANCE APPLICATION PART 2, PAGE 3 OF 3

Comments

List details of Yes answers. Identify question number: Include diagnosis, dates, prescription medications, duration, and names and addresses of all attending physicians and medical facilities (exclude any information regarding duration, medication or treatment for HIV/AIDS/ARC). Use an additional sheet of paper if necessary.

Agreement

I represent the information in this application 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.

Fraud Warning: Any person who knowingly and wih 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.

Signed at: _____ _____ Date _____
City State Mo Day Yr

_____ _____
Signature of Proposed Insured Age 15 and Over Signature of Parent or Guardian if Proposed Insured is under Age 15

_____
Signature of Other Proposed Insured Age 15 and Over

T137LFL16A

FULLY 18B

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Producer Statement

1. Has any person proposed for insurance informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? . . . . . ☐ **Yes** ☐ **No**
   If "Yes," give name(s) of the person(s) _____
   _____

2. Do you, the Producer(s), know or have reason to believe that the policy(ies) applied for has replaced or will replace any existing life insurance policies or annuity contracts? . . . . . ☐ **Yes** ☐ **No**

3. Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer's Guide and comply with all state and Company replacement requirements? ☐ **Yes** ☐ **No** **If "No," please explain** _____
   _____
   _____

4. 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**
   If "No," please explain _____
   _____
   _____

5. I conducted said interview in person ☐ **Yes** ☐ **No** **If "No," please explain** _____
   _____
   _____

_____ _____ _____

Signature of Producer # 1 Production Number Mo Day Yr

_____ _____ _____

Signature of Producer # 2 Production Number Mo Day Yr

_____

Print or Stamp Producer #1 Name

_____

Print or Stamp Producer #2 Name

_____ _____

General Agent/General Manager Name General Agent/General Manager Stamp

C997LNA09A

PLEASE SUBMIT ALL PAGES

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Producer's Report

(Must be completed by the Producer who obtained the application on the Proposed Primary Insured named below.)

1 Is Proposed Primary Insured self-supporting? ❑ Yes ❑ No

If "No," provide the following information about the person on whom Proposed Primary Insured is dependent:

Full Name _____ Address _____ Birth Date _____

Amount of life insurance carried with all companies $ _____ If none, state why _____

2 If Proposed Primary Insured used a different name in past, give previous different full name(s) _____

_____

3 Are you related to the Proposed Primary Insured or Owner? ❑ Yes ❑ No If answered "Yes," state relationship _____

4 How long have you known the Proposed Primary Insured? must be answered

5 How long have you known the Proposed Owner? must be answered

6 Have you, the producer, observed or are you aware of any additional information that may affect the issuance of this policy?

If "Yes," explain below ❑ **Yes** ❑ **No**

_____

_____

_____

7 Will any entity other than a life insurance company evaluate the Proposed Life Insured(s) medically to determine life expectancy or to otherwise obtain financing? ❑ Yes ❑ No If "Yes," provide details _____

_____

_____

_____

8 Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? ❑ Yes ❑ No

9 Rate class quoted *example: Preferred Non-Tobacco

10 Please check the Underwriting requirements ordered: ❑ Blood Profile/HOS ❑ Inspection Report ❑ MD Exam ❑ Treadmill EKG ❑ EKG ❑ Paramedical Exam Paramed Company _____

11 Previous residence(s) of Proposed Primary Insured for past five years.

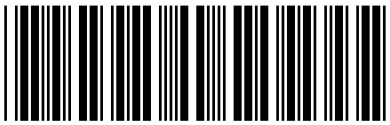
Address	From	To

Additional Comments

_____

_____

_____



United of Omaha Life Insurance Company

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

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)

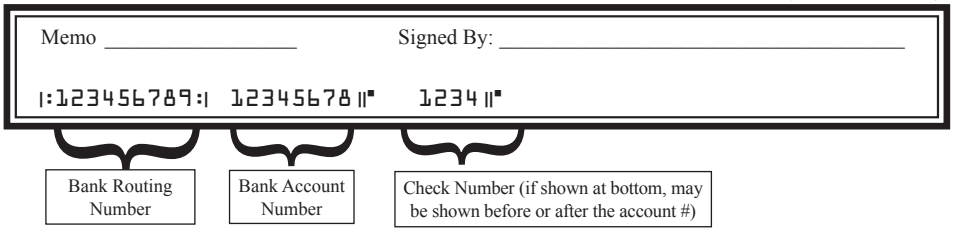
- ☐ Employer
- ☐ Business owned by Proposed Insured/Insured or spouse
- ☐ Power of Attorney or legal guardian
- ☐ Living Trust
- ☐ Other _____

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)



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

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL *of* OMAHA COMPANY

FLORIDA 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 United of Omaha Life Insurance Company, its affiliated companies (United) 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 United, 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, United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha NE 68175. A revocation is limited to the extent that United has taken action in reliance on the authorization or the law allows United 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: _____

_____

_____ **Date:** _____
Signature of Proposed Insured Mo Day Yr

_____ **Date:** _____
Signature of Spouse (if Proposed Insured) Mo Day Yr

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

_____ **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

Temporary Life Insurance Agreement ("Agreement")

United of Omaha Life Insurance Company ("United", "we", "our", "us"), Mutual of Omaha Plaza, Omaha, NE 68175

If any proposed insured dies while coverage under this Agreement is in effect, we will pay to the beneficiary(ies) named in the application the temporary insurance Benefit ("TIA Benefit") described in the section below entitled "Benefit".

Questions

If any question listed below is answered "Yes" or left blank, NO COVERAGE will take effect under this Agreement.

The questions below apply to **all** Proposed Insured(s) shown on the application.

	YES	NO
1 Within the past 90 days, has any Proposed Insured been admitted to a hospital or other medical facility, had surgery performed or recommended, or had a diagnostic test other than an HIV test by a licensed member of the medical profession?	☐	☐
2 Within the past 10 years, has any Proposed Insured been treated for heart trouble, stroke, cancer, drug or alcohol use, or had such treatment recommended by a physician or other health care provider?	☐	☐
3 Has any person proposed for insurance ever tested positive for exposure to the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐
4 Is any Proposed Insured under 15 days old or over 70 years of age?	☐	☐
5 Does amount applied for exceed $1,000,000?	☐	☐
6 Is the policy applied for a second to die life insurance policy?	☐	☐

No Coverage

There is NO temporary insurance coverage if:

1 No premium is submitted at the time this Agreement is submitted or if the premium check or electronic transaction is not honored;or
2 Any question listed above is answered "Yes" or left blank; or
3 There is a material misrepresentation in any answer to any question listed above or to any questions or statements in the application and/or any questionnaires and supplements to the application; or
4 Internal Revenue Code section 1035 exchange paperwork is received without full initial modal premium; or
5 A Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, in which case, United will not be liable under this Agreement except to return any payment paid with the application.

Benefit

For purposes of this Agreement, the TIA Benefit is an amount equal to the lesser of: (1) the amount of insurance applied for in the application; or (2) $1,000,000 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 TIA Benefit under this Agreement exceed $1,000,000.

Start Date

Any Temporary insurance coverage provided **STARTS** on the date all of the following requirements have been met:

1 This Agreement has been fully completed, signed and dated on the date of the application by the Proposed Insured(s), Applicant/Owner and Producer.
2 The full initial modal premium is received at our Home Office and made by check or authorized electronic transaction. A payment will be considered to be received only if one of the following valid items is received at our Home Office: (a) a check made payable to United of Omaha in the amount of the full first required premium; or (b) a completed and signed electronic transaction authorization for the first full premium.
3 All application information (including, but not limited to, all information necessary to complete the application and/or any questionnaires and supplements to the application) and any medical exam and tests required by United are completed. Notwithstanding the preceding sentence, if the Proposed Insured dies within 30 days after the date this Agreement is signed as a direct result of, independent from all other causes, accidental bodily injury that occurs after the date of this Agreement but before any medical exam and tests are completed, we will pay to the beneficiary(ies) named in the application the TIA Benefit.

End Date

This Agreement and any coverage provided hereunder will **END** on the earliest of the following dates:

1 90 days from the date of this Agreement; 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 a standard risk class; or (b) have declined to issue you a policy; or (c) will not provide temporary insurance coverage; or
4 The date the applicant/owner withdraws the application for insurance.

Signatures

This Agreement does not limit United in applying its underwriting standards to the application nor does this Agreement 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 Agreement 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 knowledege and belief. I/We understand that the Producer has no authority to change the terms of this Agreement.

Signature of Proposed Insured _____ Date _____

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 $_____

I/We have not received a check with the application if any question in the above section entitled "Questions" was answered "yes" or left blank. I/We agree that I/We am/are not authorized to change or waive the terms of this Agreement and represent that I/We have not attempted to do so. I/We have read and explained the terms of this Agreement to the Proposed Insured(s) and the Applicant/Owner. I/We have left a copy with the Applicant/Owner.

Signature of Producer _____ Date _____

Signature of Producer _____ Date _____

PLEASE SUBMIT TO HOME OFFICE

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

United of Omaha Life Insurance Company
A Mutual *of* Omaha Company

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefit received under any accelerated death benefit rider may be taxable. Receipt of the 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 an accelerated death benefit.

Disclosure for Term Life Insurance Policies

If you are applying for term life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness 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 charge for the rider.

Benefit Description

If the Insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit up to $1,000,000 or 80% of the policy's death benefit, whichever is less. A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by 6% of the requested acceleration and a $100 charge.

Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy will continue with a reduced face amount and a reduced premium.

Disclosure for Universal Life Insurance Policies

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Terminal Illness Rider, the Accelerated Death Benefit for Chronic Illness Rider, and their effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the riders. There is no premium or cost of insurance for these riders. The Accelerated Death Benefit for Chronic Illness Rider is not available when the Long-Term Care Benefits Rider is issued.

Benefit Description - Accelerated Death Benefit For Terminal Illness Rider

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit. The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

A Terminal Illness is a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date a physician signs the statement of proof of terminal illness.

We will reduce the Terminal Illness benefit by 6% of the requested acceleration, a $100 charge, and the pro-rated amount of any outstanding loans.

Benefit Description - Accelerated Death Benefit for Chronic Illness Rider - (This rider is not available when the Long-Term Care Benefits Rider is issued.)

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means that within the last 12 months a physician has certified that for a continuous period of at least 90 days, the insured is: (a) unable to perform (without substantial assistance from another person) at least two activities of daily living; or (b) requires substantial supervision to protect himself or herself from threats and safety due to severe cognitive impairments.

The sum of all requested accelerations may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration. Each requested acceleration may not exceed the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the insured is expected to be Chronically Ill. The Internal Revenue Service announces the per diem limit for each calendar year.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by a charge equal to 6% of the requested acceleration multiplied by the insured's life expectancy in years, a $100 charge, and the pro-rated amount of any outstanding loans.

Effect of the Accelerated Death Benefit on the Policy

When we pay any accelerated death benefit, the following will occur: (a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the death benefit; and (b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.

Acknowledgment

I acknowledge receipt of this Disclosure Form

Applicant/Owner Signature _____ Date _____

I have provided this Disclosure Form to the Applicant

Producer Signature _____ Date _____

Third Party Notice

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 extra notice will be sent at least 21 days prior to the effective date of cancellation of your policy or certificate only if you are age 64 or older. This notice will state the amount of premium, the date by when the premium must be paid 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 and address.

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)

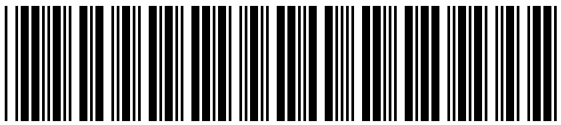
Signature of Policyowner/Certificateholder

_____

Date _____

Section 2

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



Signature of Policyowner/Certificateholder

_____

Date _____

United *of* Omaha Life Insurance Company Attn: Individual Life Underwriting 9330 State Hwy 133, Blair, 68008

L2401_0604

Notice and Consent for AIDS Related Testing

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

To evaluate your insurability, the insurer named above (the insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by certified laboratory through a medically accepted procedure. Many public health organizations have recommended that before taking an AIDS-related test, a person seeking counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

The HIV Antibody Test

A series of tests will be performed by a licensed laboratory through a medically accepted procedure to determine whether you may have been infected with the HIV virus. This test is not a test for acquired immunodeficiency syndrome (AIDS). AIDS is a disease you get when HIV destroys your body's immune system, and can only be diagnosed by medical evaluation.

An initial ELISA blood test will be done. If the initial ELISA test is positive, then a repeat ELISA test will be performed. If the second ELISA test is positive, a Western Blot test will be conducted to confirm the positive ELISA test results.

Potential Uses

The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank.

There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

Limitations

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health and Rehabilitation. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result _____

Address _____

Consent

I have read and I understand this Notice and Consent for AIDS-Related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluid from me, the testing of that blood and/or other bodily fluid, and the disclosure of the test results as described herein.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured _____

Address _____

_____ _____

Signature of Proposed Insured or Parent/Guardian Date Signed

PLEASE SUBMIT