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

Michigan – Application for Life Insurance

Simplified issue 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

☞ Please choose the precise Product, Plan, Rider, and amount of insurance applied for

❑ **Universal Life Product:**
- Guaranteed Universal Life Express
- Legacy SPL

❑ **Single Premium Legacy Rider:**
- Accidental Death Benefit Rider

❑ **Guaranteed Universal Life Express Rider:**
- Accidental Death Benefit Rider
- Guaranteed Insurability Rider
- Disability Rider • Dependent Children's Rider

❑ **Term Product:**
- Term Life Express

❑ **Term Life Rider:**
- Accidental Death Benefit Rider
- Dependent Children's Rider
- Disability Income Rider
- Disability Waiver of Premium Rider

Application Submission Guidelines

❑ Attach a cover letter or additional information as needed.

❑ Always submit the Producer Statement and Producer Report page.

❑ Always obtain signed MIB and HIPAA authorizations.

❑ Always provide client with MIB Inc Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Investigative Consumer Reports Notice, Summary of Rights, and Life Insurance Buyer's Guide.

❑ 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.

Important Forms

❑ Replacement Notice – if applicable, the client must sign and retain a copy for their records

❑ Bank Service Plan – Complete the Monthly Bank Withdrawal form if applicable

❑ Conditional Receipt – Complete ONLY if you accepted a check at time of sale for the initial premium

❑ Accelerated Benefit Rider Disclosure – The client must sign the Accelerated Benefit Rider Disclosure Form

❑ HIV Consent Form (If Required by State) – If the face amount is $250,000 or over you will need a signed HIV consent form. If your state does not require an HIV form, it will not be included in the packet.

Supplemental Applications, Forms, and Buyer's Guide:

- ***Child(s) Rider Supplemental Application:*** If applying for the children's rider complete the Child(s) Rider Supplemental Application.
- ***Disability Income/Waiver Supplemental Application:*** If applying for the disability waiver or a rider offering disability benefits complete the Disability Income/Waiver Supplemental Application.
- ***Acknowledgment/Illustration Certification form:*** 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.

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Mutual of Omaha Plaza, Omaha, NE 68175

PART 1, PAGE 1 OF 2 LIFE INSURANCE APPLICATION

PROPOSED INSURED

Proposed Insured Legal Name _____

Gender ☐ Male ☐ Female Height _____ Weight _____ Social Security No. _____

Date of Birth _____ State of Birth _____ Annual Income _____

Driver's License No. _____ Driver's License State _____

Legal Residence Address _____
Street

_____
City State ZIP

Best Time to Call _____ Phone No. _____ E-mail _____

Occupation/Duties _____ Employer _____

PLAN INFORMATION

Term Life Express Amount of Insurance Applied for $_____

Term Life: ☐ 30-Year Level Term Life with 5 Year Guarantee ☐ 30-Year Level Term Life with 30 Year Guarantee

☐ 20-Year Level Term Life with 5 Year Guarantee ☐ 20-Year Level Term Life with 20 Year Guarantee

☐ 15-Year Level Term Life with 15 Year Guarantee

Return of Premium Term (not available for 5-Year or 15-Year Guarantee) ☐ **Yes**

☞ Complete Supplemental Application(s) if applying for: (1) the disability waiver or a rider offering disability income, or (2) the Children's Rider.

Term Riders

☐ Disability Income Rider (not available with Return of Premium): ☐ 18 months ☐ 30 months

Disability Income Rider Monthly Benefit $ _____

☐ Disability Waiver of Premium Rider

☐ Dependent Children's Rider Benefit Amount of Insurance Applied for ☐ $5,000 ☐ $10,000

☐ Accidental Death Benefit Rider Amount of Insurance Applied for $ _____

Permanent Life:

☐ Guaranteed Universal Life Express Amount of Insurance Applied for $ _____

☐ Single Premium Life Amount of Insurance Applied for $ _____

Permanent Life Riders

☐ Dependent Children's Rider Benefit Amount of Insurance ☐ $5,000 ☐ $10,000

☐ Accidental Death Benefit Rider Amount of Insurance Applied for $ _____ ☐ Waiver of Premium Rider

Payment Mode ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft ☐ Other _____

Modal Premium $_____ Collected Premium $_____

OWNER

Complete Policyowner information if Proposed Insured is not the Policyowner

Name of Policyowner _____ Date of Birth _____

Relationship to Proposed Insured _____ Social Security No./Tax ID _____

Citizenship Country _____ Phone No. _____

Policyowner Address _____
Street City State ZIP

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

Name _____

Mailing Address _____
Street City State ZIP

If more space is needed, provide information in Comments section.

BENEFICIARY

Primary Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth
Contingent Beneficiary	**% of Proceeds**	**Relationship to Insured**	**Date of Birth**

If more space is needed, provide information in Comments section.

OTHER COVERAGE INFORMATION

1. Has the Proposed Insured 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. List below all life insurance policies and/or annuity contracts on any person proposed for insurance that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt.)
If none, check the following box ..... ☐ **None**

5. Has the Proposed Insured had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? ..... ☐ **Yes** ☐ **No**

Please complete the box(es) below.

The Producer shall comply with any additional state and/or company replacement requirements.

Company	Policy or Contract Number	Face Amount	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
					☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	
					☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	
					☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	
					☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	
					☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	

COMMENTS

Provide any additional information necessary and the details of "Yes" answers. Always identify question number.

UNITED OF OMAHA LIFE INSURANCE COMPANY

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

PART 2, PAGE 1 OF 2 LIFE INSURANCE APPLICATION

UNDERWRITING

If the Proposed Insured answers "Yes" to questions 1 through 7 in this section, that person is not eligible for coverage under this application.

	Proposed Insured
1. Has the Proposed Insured ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
2. Has the Proposed Insured **ever** (a) received care or treatment for, or (b) been advised by a member of the medical profession to seek treatment for, or (c) consulted with a health care provider regarding:	
(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Heart Murmur/Valvular Heart Disease or Replacement, Cardiomyopathy, Congenital Heart Disease, Stroke/mini-stroke, abnormal heart rhythm, or Cerebral or Symptomatic Aneurysm?	☐ Yes ☐ No
(b) Chronic Lung Disease (except mild Asthma), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis?	☐ Yes ☐ No
(c) Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's Disease, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, Paraplegia, Down's Syndrome, Autism, or any other disease of the central nervous system?	☐ Yes ☐ No
(d) Chronic Kidney Disease, end-stage Renal Disease with dialysis, or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C?	☐ Yes ☐ No
(e) Diabetes with onset before age 50 or with vascular or renal complications?	☐ Yes ☐ No
(f) Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell or squamous cell skin cancer)?	☐ Yes ☐ No
(g) Systemic Lupus or Scleroderma?	☐ Yes ☐ No
(h) an organ transplant?	☐ Yes ☐ No
3. In the past 12 months, has the Proposed Insured:	
(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
(b) received, or been advised 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, speech therapy, or is the Proposed Insured currently confined to any hospital or other medical facility?	☐ Yes ☐ No
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	☐ Yes ☐ No
(d) applied for, received, or is the Proposed Insured currently receiving, disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity, fractures, spinal or back disorders?	☐ Yes ☐ No
4. In the past 12 months, has the Proposed Insured:	
(a) been advised by a member of the medical profession to have a surgical operation, diagnostic testing other than for routine screening purposes, treatment, or other procedure which has not been done?	☐ Yes ☐ No
(b) consulted a member of the medical profession for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding?	☐ Yes ☐ No
5. In the next 2 years, will the Proposed Insured engage in any motor sports racing, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing?	☐ Yes ☐ No
6. In the past 10 years, has the Proposed Insured:	
(a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a member of the medical profession?	☐ Yes ☐ No
(b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	☐ Yes ☐ No
(c) been convicted of or incarcerated for a felony?	☐ Yes ☐ No
(d) been hospitalized for high blood pressure or any mental or nervous disorder?	☐ Yes ☐ No
7. In the past 5 years, has the Proposed Insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had four or more moving violations?	☐ Yes ☐ No

UNDERWRITING

	Proposed Insured
8. Is the Proposed Insured a citizen of the United States? ..... **If "No," complete the Foreign National questionnaire.**	☐ **Yes** ☐ **No**
9. Has the Proposed Insured ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy?	☐ **Yes** ☐ **No**

If "Yes," please list details below.

Person Proposed for Insurance	Form of Tobacco/Nicotine Replacement Therapy	Frequency	Date Stopped

10. Name and address of personal physician if the Proposed Insured is over age 60.

_____

_____

_____

AGREEMENT

Each of the undersigned certify that we have read the completed application.

1. All answers in this application are true and complete, to the best of my knowledge and belief, and will be relied on by United of Omaha to determine insurability. The statements and answers in the application are the basis for any policy issued by United of Omaha, and no information about them will be considered to have been given to United of Omaha unless it is stated in the application. Any incorrect or misleading answers may void this application and any issued policy effective the issue date.
2. If mode of payment is Bank Service Plan, I/We authorize premiums due to be automatically paid to United of Omaha, by electronic fund transfer until this authorization is cancelled in writing.
3. Until this application is approved for issue by United of Omaha's Underwriting Department, no policy will be issued and no coverage will be provided except by a Conditional Receipt, if provided. In no event will benefits be paid for the same loss under both a Conditional Receipt and any policy issued from this application.
4. The issue date of the policy will be the date shown in the policy, even though coverage may not become effective until a later date. Coverage under the issued policy will become effective only if and when: (a) the full initial premium is paid or, if paid by electronic funds transfer, the full initial premium is received by United of Omaha, and (b) United of Omaha Life Insurance Company has been notified of any change in either the health or habits of any person proposed for insurance between the date the application is approved for issue and the date the policy is delivered, and (c) the policy is delivered and all delivery requirements are completed during the lifetime of the Proposed Insured.
5. If, prior to policy delivery, any person proposed for insurance dies, or there has been a change in that person's health or habits that will change any statement or answer to any question in the application, we will immediately notify United of Omaha. If the person proposed for insurance is not eligible for the insurance applied for, we agree that no policy of any kind will be in effect.
6. I have received the MIB Inc. Pre-Notice, the Notice of Information Practices, and a Life Insurance Buyer's Guide before completing this application.
7. If the applicant is other than the person proposed for insurance, the applicant will own the policy.
8. No Producer can: (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.
9. **Fraud Warning:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
10. The application includes Part I and Part 2, and 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.

I have read and understand the Authorization to Receive Information from and Disclose Information to the MIB Inc. ("MIB"), the Agreement Section and the Conditional Receipt provided, and I approve all my answers as recorded in this application.

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 Payor as shown on bank account if Payment mode is BSP **and** payor is other than Proposed Insured or Other Proposed Insured.

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

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 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** _____

_____

6. **(a)** Are you related to the Proposed Insured or Owner? ☐ **Yes** ☐ **No** **If "Yes," state relationship** _____

_____

(b) How long have you known the Proposed Insured? _____

(c) How long have you known the proposed Owner? _____

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

Address	From	To

_____ _____ _____

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

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

MONTHLY BANK WITHDRAWALS BY UNITED OF OMAHA LIFE INSURANCE COMPANY ("United of Omaha")

The withdrawal from the bank account identified below for the initial premium(s) due will occur only if and when the application(s) is/are approved for issue by United of Omaha. The withdrawal for renewal premiums due will occur on the date specified below.

- Social Security No. of Payor – if other than Proposed Insured or Owner
- Specify the date renewal premiums will be withdrawn (1st through the 28th of each month)
- If no date is specified, renewal premiums will be withdrawn each month on the day that matches the policy issue date.

AUTHORIZATION TO WITHDRAW FUNDS BY UNITED OF OMAHA LIFE INSURANCE COMPANY ("United of Omaha")

(If Mode of Payment is Monthly BSP - select one below)

- Monthly Bank Service Plan **(initial premium collected with the application)**
- Monthly Bank Service Plan **(initial premium** to be paid by electronic transfer)

Complete information below OR attach a voided check**:**

Routing No. (9-digit No.. See sample check below)

Account No.

Name of Payor as shown on account

First Initial

Last

ATTACH CHECK HERE

Submit To Home Office

L8240

HWA600

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

MICHIGAN AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

To: physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations, MIB (Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members), insurers, employers, consumer reporting agencies and all other providers of medical or dental services.

I authorize you to release to representatives of Mutual of Omaha Insurance Company or its affiliated companies (Mutual), personal information about me including: medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, alcohol or drug use, financial and occupational information in order to determine eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with a claim.

I also authorize Mutual to disclose my personal information to the MIB. I understand that my 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.

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.

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

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

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

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

PLEASE SUBMIT ALL PAGES

L8232_MI

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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. Proposed Primary
Insured Full Name _____
First Name Initial Last Name

2. Please Note: A recent mortgage is not required for issuance of this policy.

Has the Proposed Insured purchased a home or refinanced a home within the last 2 years? ..... ☐ **Yes** ☐ **No**
If "Yes," then complete the remainder of Question 2

Approximate Mortgage Loan Amount $ _____

Mortgage Loan Financial Institution Name _____

3. 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**

_____

_____

_____

_____

_____

_____

PLEASE SUBMIT ALL PAGES

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefit received under the 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 the 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 or cost of insurance charge for the rider.

Benefit Description

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 92% of the policy's death benefit.[1] A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 24 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness.

[1] *In* ***Indiana,*** 94%.

Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

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 and Chronic 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 or cost of insurance charge for the rider.

Benefit Description

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness or as being Chronically Ill, you may elect to receive an accelerated death benefit. 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 on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness. Chronically Ill means that the Insured is unable to perform at least two Activities of Daily Living and has been confined to a Nursing Home for 90 consecutive days or more. [2] A physician must certify that the Insured is Chronically Ill.

For Single Premium Life [3]

For the Terminal Illness benefit, you may elect to receive 50% of the policy's current death benefit. For the Chronic Illness benefit, you may elect to receive 20% to 80% of the policy's current death benefit. We will reduce the requested Chronic Illness benefit by an actuarial discount as determined by factors in the rider. We will pay an accelerated death benefit only once. When we pay the accelerated death benefit, the rider will terminate.

For All Other Universal Life

The amount available for an accelerated death benefit depends on your policy's current death benefit and the provisions of your policy. The aggregate total of all elections may not exceed $250,000. You may elect to receive the Chronic Illness benefit more than once. 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 requested Chronic Illness benefit by an actuarial discount as determined by the factors in the rider. For the Terminal Illness benefit, we will reduce the requested amount by 6%. We will also adjust the Terminal Illness benefit and each Chronic Illness benefit by a $100 charge and the pro-rated amount of any outstanding loans. The rider will terminate when the Terminal Illness benefit is paid or the aggregate total of all elections reaches $250,000.

[2] *In* **Kansas**, *Activities of Daily Living requirement not applicable.*

In **Virginia**, *Nursing Home confinement requirement not applicable.*

In **Minnesota**, *and* **North Carolina**, *Nursing Home confinement must be expected to last for the duration of the Insured's life.*

In **Minnesota,** *Chronically Ill may also mean the Insured requires substantial and protective supervision due to Severe Cognitive Impairment.*

[3] *In* **Connecticut, Maryland, Minnesota, Mississippi, Puerto Rico, Virgin Islands**, *and* **Vermont,** *the Accelerated Benefit Rider for Single Premium Life is not available.*

Effect of the Accelerated Death Benefit on the Policy

If your policy includes a Return of Premium Benefit provision, we will reduce the premium used to calculate the Return of Premium benefit by the benefit paid. We will reduce the current amount of insurance coverage, tabular value, accumulation value, surrender value, and any policy loan by the same proportion as the requested reduction in the death benefit. We will base the future premium and policy charges on the reduced amount of insurance coverage.

Acknowledgment

I acknowledge receipt of this Disclosure Form

Applicant/Owner Signature _____ Date _____

I have provided this Disclosure Form to the Applicant

Producer Signature _____ Date _____

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Conditional Receipt

A Conditional Receipt ("Receipt") requires that the applicant submit a check for the first modal premium.

A check dated _____ for $_____ from _____
Mo Day Yr

covering the lives of _____accompanies this Receipt.
(Person(s) Proposed for Insurance)

ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO UNITED OF OMAHA LIFE INSURANCE COMPANY ("UNITED OF OMAHA"). DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

This Receipt is furnished in connection with an application for insurance on the above proposed insured(s) bearing the same date as this Receipt. Insurance under this Receipt will become effective on the Effective Date defined below, but only if **all** conditions below have been completely met:

(1) The amount received is sufficient to pay: (a) the first premium of a fixed premium plan, at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan.

(2) All required medical examinations must be completed within 60 days from the date of the application.

(3) Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United of Omaha then in effect, without modification of the plan, premium rate, benefits, class and amount of coverage applied for.

(4) To the best knowledge and belief of those signing the application all the statements and answers in the application are true and complete when made.

(5) All parts of the application, and if required, supplements to the application, questionnaires and amendments to the application are completed and received by United of Omaha.

If any of the above conditions are not met or if any proposed insured dies by suicide, the liability of United of Omaha will be limited to the return of the premium paid.

CONDITIONAL INSURANCE COVERAGE: The amount of conditional insurance coverage provided under this Receipt, if any, shall not exceed $100,000 and shall also not exceed the death benefit applied for. If United of Omaha does not approve and accept the application for insurance within 60 days of the Effective Date of this Receipt, conditional insurance coverage will cease. In that case, United of Omaha's liability will be limited to the return of the premium paid. United of Omaha has the right to terminate conditional insurance coverage at any time prior to the expiration of 60 days of the Effective Date of this Receipt by mailing a refund of the premium paid.

Effective Date: If all the conditions above are met, then insurance under this Receipt, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the later of: (a) the date of application; or (b) the date of completion of all underwriting requirements stated in (2) above.

No producer is authorized to waive or modify any of the provisions of this Receipt.

This Receipt is furnished in connection with an application for insurance bearing the same date as this Receipt. In no event will benefits be paid for the same loss under both the applied for issued policy and this Receipt.

I understand and agree to the terms, conditions and limits of this Receipt that have been fully explained to me by the producer.

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

_____
Signature of Proposed Insured (Age 14 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 14 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)

PLEASE SUBMIT ALL PAGES

Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

- ❑ ATTN: Health: Records/Mailing Processing Center, Individual Life Underwriting, State Hwy 133, Blair, NE 68008
- ❑ ATTN: Life Agency: Individual Life Underwriting, State Hwy 133, Blair, NE 68008
- ❑ ATTN: Life Brokerage: Individual Life Underwriting, State Hwy 133, Blair, NE 68008

The HIV Antibody Test

To evaluate your Insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood or fluid from cells in the mouth 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.

How is HIV transmitted and Prevention?

HIV is transmitted through contact with infected body fluids such as blood, semen, vaginal secretions, and breast milk. It is spread by sexual contact with an infected person, and by sharing needles and/or syringes (primarily for drug injection) with someone who is infected. Very rarely, HIV is transmitted through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast feeding after birth.

The best way to avoid HIV infection is to avoid behaviors that would involve exposure to infected body fluids, including unprotected sexual intercourse or sharing needles to inject drugs.

Meaning of Test Results

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, **Please write in the physician and/or health facility name who will receive the HIV test results** so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician _____

Address _____

Consent

I have been informed that my blood or oral sample from my mouth will be tested for the Human Immunodeficiency Virus (HIV), the virus that causes AIDS. I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to _____* and as permitted under state law.

I understand that I have a right to have this test be done without the use of my name. I understand I may obtain anonymous testing at a Michigan Community Public Health Agency-approved HIV counseling and testing site. I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

By my signature below, I consent to be tested for HIV.

_____ Date _____

Signature of Proposed Insured/ Parent/Guardian

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS

_____ Date _____

Signature of Proposed Insured/ Parent/Guardian

PLEASE SUBMIT ALL PAGES

Important Documents

Client Forms
Follow this page

Producer: Conditional Receipt
The customer copy must not be given to the applicant **if a check for the initial premium was not collected** at the time of application.

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Conditional Receipt

A Conditional Receipt ("Receipt") requires that the applicant submit a check for the first modal premium.

A check dated _____ for $_____ from _____
Mo Day Yr

covering the lives of _____accompanies this Receipt.
(Person(s) Proposed for Insurance)

ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO UNITED OF OMAHA LIFE INSURANCE COMPANY ("UNITED OF OMAHA"). DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

This Receipt is furnished in connection with an application for insurance on the above proposed insured(s) bearing the same date as this Receipt. Insurance under this Receipt will become effective on the Effective Date defined below, but only if **all** conditions below have been completely met:

(1) The amount received is sufficient to pay: (a) the first premium of a fixed premium plan, at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan.

(2) All required medical examinations must be completed within 60 days from the date of the application.

(3) Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to the underwriting standards of United of Omaha then in effect, without modification of the plan, premium rate, benefits, class and amount of coverage applied for.

(4) To the best knowledge and belief of those signing the application all the statements and answers in the application are true and complete when made.

(5) All parts of the application, and if required, supplements to the application, questionnaires and amendments to the application are completed and received by United of Omaha.

If any of the above conditions are not met or if any proposed insured dies by suicide, the liability of United of Omaha will be limited to the return of the premium paid.

CONDITIONAL INSURANCE COVERAGE: The amount of conditional insurance coverage provided under this Receipt, if any, shall not exceed $100,000 and shall also not exceed the death benefit applied for. If United of Omaha does not approve and accept the application for insurance within 60 days of the Effective Date of this Receipt, conditional insurance coverage will cease. In that case, United of Omaha's liability will be limited to the return of the premium paid. United of Omaha has the right to terminate conditional insurance coverage at any time prior to the expiration of 60 days of the Effective Date of this Receipt by mailing a refund of the premium paid.

Effective Date: If all the conditions above are met, then insurance under this Receipt, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the later of: (a) the date of application; or (b) the date of completion of all underwriting requirements stated in (2) above.

No producer is authorized to waive or modify any of the provisions of this Receipt.

This Receipt is furnished in connection with an application for insurance bearing the same date as this Receipt. In no event will benefits be paid for the same loss under both the applied for issued policy and this Receipt.

I understand and agree to the terms, conditions and limits of this Receipt that have been fully explained to me by the producer.

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

_____
Signature of Proposed Insured (Age 14 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 14 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)

GIVE THIS COPY TO THE APPLICANT

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefit received under the 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 the 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 or cost of insurance charge for the rider.

Benefit Description

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness, you may make a one-time election to receive an accelerated death benefit equal to 92% of the policy's death benefit.[1] A Terminal Illness is a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 24 months or less from the date on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness.

[1] *In* ***Indiana,*** *94%.*

Effect of the Accelerated Death Benefit on the Policy

When we pay the accelerated death benefit, the policy and all its riders will terminate.

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 and Chronic 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 or cost of insurance charge for the rider.

Benefit Description

While the rider is in force and if the Insured is diagnosed as having a Terminal Illness or as being Chronically Ill, you may elect to receive an accelerated death benefit. 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 on the statement of proof of Terminal Illness. A physician must sign and date the statement of proof of Terminal Illness. Chronically Ill means that the Insured is unable to perform at least two Activities of Daily Living and has been confined to a Nursing Home for 90 consecutive days or more. [2] A physician must certify that the Insured is Chronically Ill.

For Single Premium Life [3]

For the Terminal Illness benefit, you may elect to receive 50% of the policy's current death benefit. For the Chronic Illness benefit, you may elect to receive 20% to 80% of the policy's current death benefit. We will reduce the requested Chronic Illness benefit by an actuarial discount as determined by factors in the rider. We will pay an accelerated death benefit only once. When we pay the accelerated death benefit, the rider will terminate.

For All Other Universal Life

The amount available for an accelerated death benefit depends on your policy's current death benefit and the provisions of your policy. The aggregate total of all elections may not exceed $250,000. You may elect to receive the Chronic Illness benefit more than once. 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 requested Chronic Illness benefit by an actuarial discount as determined by the factors in the rider. For the Terminal Illness benefit, we will reduce the requested amount by 6%. We will also adjust the Terminal Illness benefit and each Chronic Illness benefit by a $100 charge and the pro-rated amount of any outstanding loans. The rider will terminate when the Terminal Illness benefit is paid or the aggregate total of all elections reaches $250,000.

[2] *In* **Kansas**, *Activities of Daily Living requirement not applicable.*

In **Virginia**, *Nursing Home confinement requirement not applicable.*

In **Minnesota**, *and* **North Carolina**, *Nursing Home confinement must be expected to last for the duration of the Insured's life.*

In **Minnesota,** *Chronically Ill may also mean the Insured requires substantial and protective supervision due to Severe Cognitive Impairment.*

[3] *In* **Connecticut, Maryland, Minnesota, Mississippi, Puerto Rico, Virgin Islands**, *and* **Vermont,** *the Accelerated Benefit Rider for Single Premium Life is not available.*

Effect of the Accelerated Death Benefit on the Policy

If your policy includes a Return of Premium Benefit provision, we will reduce the premium used to calculate the Return of Premium benefit by the benefit paid. We will reduce the current amount of insurance coverage, tabular value, accumulation value, surrender value, and any policy loan by the same proportion as the requested reduction in the death benefit. We will base the future premium and policy charges on the reduced amount of insurance coverage.

Acknowledgment

I acknowledge receipt of this Disclosure Form

Applicant/Owner Signature _____ Date _____

I have provided this Disclosure Form to the Applicant

Producer Signature _____ Date _____

Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

- ❑ ATTN: Health: Records/Mailing Processing Center, Individual Life Underwriting, State Hwy 133, Blair, NE 68008
- ❑ ATTN: Life Agency: Individual Life Underwriting, State Hwy 133, Blair, NE 68008
- ❑ ATTN: Life Brokerage: Individual Life Underwriting, State Hwy 133, Blair, NE 68008

The HIV Antibody Test

To evaluate your Insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood or fluid from cells in the mouth 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.

How is HIV transmitted and Prevention?

HIV is transmitted through contact with infected body fluids such as blood, semen, vaginal secretions, and breast milk. It is spread by sexual contact with an infected person, and by sharing needles and/or syringes (primarily for drug injection) with someone who is infected. Very rarely, HIV is transmitted through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast feeding after birth.

The best way to avoid HIV infection is to avoid behaviors that would involve exposure to infected body fluids, including unprotected sexual intercourse or sharing needles to inject drugs.

Meaning of Test Results

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, **Please write in the physician and/or health facility name who will receive the HIV test results** so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician _____

Address _____

Consent

I have been informed that my blood or oral sample from my mouth will be tested for the Human Immunodeficiency Virus (HIV), the virus that causes AIDS. I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to _____* and as permitted under state law.

I understand that I have a right to have this test be done without the use of my name. I understand I may obtain anonymous testing at a Michigan Community Public Health Agency-approved HIV counseling and testing site. I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

By my signature below, I consent to be tested for HIV.

_____ Date _____

Signature of Proposed Insured/ Parent/Guardian

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS

_____ Date _____

Signature of Proposed Insured/ Parent/Guardian

GIVE THIS COPY TO THE APPLICANT

United of Omaha Life Insurance Company – MIB , Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. United of Omaha Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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 is: 50 Braintree Hill Park, Suite 400, Boston, MA 02184-8734.

United of Omaha Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Disclosure Statement

Mutual of Omaha Insurance Company and/or United of Omaha Life Insurance Company, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request we will provide you with additional disclosures relating to the nature and scope of the investigative consumer report. Following this Disclosure Statement is a written Summary of Your Rights under Section 609 (c) of the Fair Credit Reporting Act, as amended.

If you request the additional disclosures from either United of Omaha Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address: Attention: Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, Nebraska 68175.

United of Omaha Life Insurance – Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

Investigative Consumer Reports Notice

United of Omaha Life Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

GIVE THIS COPY TO THE APPLICANT

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 1-202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 1-800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 1-703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation , Office of Financial Management Washington, DC 20590 1-202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 1-202-720-7051

L8249

GIVE THIS COPY TO THE APPLICANT