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

APPLICATION FOR WHOLE LIFE EXPRESS

MICHIGAN

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

✍ *Checklist for Submitting a Completed 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

☐ **Application**
1. Answer all questions completely and legibly.
2. If citizenship question is answered "No," complete Foreign National and Foreign Travel Questionnaire.
3. Be sure the application is signed and dated in all places indicated by the Proposed Insured and the applicant if other than the Proposed Insured.
4. Any changes should be initialed by the Proposed Insured and, if applicable, the Applicant.
5. Use age last birthday.

☐ **Have Client sign 'Authorization to Disclose Personal Information' (HIPAA Authorization) and submit with application**.

☐ **Complete Premium Collection Section**
A full modal premium is collected at the time of application unless the Bank Service Plan (BSP) is selected.

☐ **Have Client sign 'Conditional Receipt'**
Submit the Conditional Receipt with the application if premium is collected at time of application.

☐ **Attach copy of the proposal illustration (if available)**

☐ **Leave all applicable forms and Life Buyer's Guide with the Proposed Insured.**

☐ **Financial Institution Consumer Disclosure**
If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

☐ **Any Additional Information or Comments**
Include any supplemental information about your client

_____

_____

_____

_____

_____

DO NOT DETACH – MUST BE SUBMITTED WITH THE APPLICATION

United of Omaha Life Insurance Company

A Mutual of Omaha Company

Mutual of Omaha Plaza, Omaha, NE 68175

Application for Individual Whole Life Insurance

Section A **PROPOSED INSURED INFORMATION**

Name (First, Middle Initial, Last) Email

Mailing Address City State ZIP Code

Social Security Number	Sex	Date of Birth	Age	Telephone Number
– –	☐ Male ☐ Female	/ /		( ) –

Secondary Addressee Information. Please provide name and address (A copy of any notification of possible policy lapse will be sent to this person) (Optional)

Are you a citizen of the United States?..... ☐ **Yes** ☐ **No**

(If "No," complete Foreign National and Foreign Travel Questionnaire and list details below.)

Documentation (select one): ☐ Permanent Resident Card (Card number _____)

☐ Visa (specify type _____)

Date of Arrival in the United States: _____ /_____

Owner/Applicant Information (Complete only if Owner/Applicant is different from Proposed Insured)

Owner's Name (First, Middle Initial, Last) Email

Owner's Mailing Address City State ZIP Code

Social Security Number	Sex	Date of Birth	Age	Telephone Number
– –	☐ Male ☐ Female	/ /		( ) –

Relationship to Proposed Insured

Are you a citizen of the United States?..... ☐ **Yes** ☐ **No**

(If "No," complete Foreign National and Foreign Travel Questionnaire and list details below.)

Documentation (select one): ☐ Permanent Resident Card (Card number _____)

☐ Visa (specify type _____)

Date of Arrival in the United States: _____ /_____

Section B **UNDERWRITING INFORMATION (Complete if applying for Whole Life Express)**

Height _____ Weight _____ Birth State _____

Driver's License Number/State of Issue _____

In the past 12 months, has the proposed insured used any form of tobacco or nicotine replacement therapy? ..... ☐ **Yes** ☐ **No**

IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN SECTION B, THAT PERSON IS NOT ELIGIBLE FOR WHOLE LIFE EXPRESS COVERAGE.

	Yes	No
1. Has the Proposed Insured **ever** been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider?	☐	☐
2. Is the Proposed Insured **currently**:		
(a) bedridden or confined to any hospital, nursing home, or other medical facility?	☐	☐
(b) using any of the following: wheelchair, electric scooter, oxygen or catheter?	☐	☐
3. **In the past 6 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?.....	☐	☐
(b) received, or been advised by a member of the medical profession to have, any of the following: care in a nursing home, assisted living facility, adult day care facility; or home health care services?.....	☐	☐

Section B	UNDERWRITING INFORMATION – continued		
		Yes	**No**
4.	Has the Proposed Insured **ever** (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:		
	(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?	☐	☐
	(b) Chronic Lung Disease (except mild Asthma), Chronic Bronchitis, Emphysema, Sarcoidosis or Cystic Fibrosis?	☐	☐
	(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?	☐	☐
	(d) Chronic Kidney Disease, end-stage Renal Disease with dialysis or Liver Disease including Cirrhosis, Hepatitis B or Hepatitis C?	☐	☐
	(e) Diabetes with onset before age 50 or with vascular or renal complications?	☐	☐
	(f) Cancer, Leukemia, Melanoma or any other internal cancer (except basal cell or squamous cell skin cancer)?	☐	☐
	(g) an organ transplant?	☐	☐
	(h) Systemic lupus or Scleroderma?	☐	☐
5.	**In the past 10 years,** has the Proposed Insured:		
	(a) used alcohol to a degree that required medical treatment or been advised by a physician to limit or discontinue its use?	☐	☐
	(b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed by a physician (including sedatives, tranquilizers, or narcotics)?	☐	☐
	(c) been convicted of or incarcerated for a felony?	☐	☐
6.	**In the past 5 years,** has the Proposed Insured:		
	(a) been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or been convicted of 4 or more moving violations?	☐	☐
	(b) been hospitalized for high blood pressure or any mental or nervous disorder by a member of the medical profession?	☐	☐
7.	**In the next 2 years,** will the Proposed Insured engage in any motor sports racing or activities, boat racing, parachuting, hang gliding, rock or mountain climbing, or skydiving?	☐	☐
8.	**In the past 12 months,** has the Proposed Insured been advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes, treatment, or other procedure which has not been done?	☐	☐
9.	**In the past 12 months,** has the Proposed Insured consulted a physician for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding?	☐	☐

Section C PLAN AND BENEFICIARY INFORMATION

Plan Information

☐ Whole Life Express

Face Amount $_____ Modal Premium $_____ Amount Collected $_____

Beneficiary Information

Primary Beneficiary Name	Contingent Beneficiary Name
Relationship	Relationship
Social Security Number – –	Social Security Number – –

Section D OTHER COVERAGE AND REPLACEMENT INFORMATION

1. List below all life insurance policies and/or annuity contracts on the Proposed Insured 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 or within an unconditional refund period.) If none, check the following box: ..... ☐ None

2. Have you had, or do you intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? ..... ☐ Yes ☐ No
If "Yes," complete the appropriate box(es) below.
The Producer shall comply with any additional state and/or company replacement requirements.

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

Section E BILLING INFORMATION

Method of Payment: ☐ Annual ☐ Semiannual ☐ Quarterly
☐ Monthly Bank Service Plan (select one below)

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

(If Mode of Payment is Monthly Bank Service Plan (BSP) – select one below)

☐ Monthly Bank Service Plan **(initial premium collected with the application)** — I/We have paid the initial premium by check to United of Omaha.

☐ Monthly Bank Service Plan **(initial premium paid by electronic funds transfer)**— I/We authorize the initial premium for the policy(ies) to be paid to United of Omaha, by electronic funds transfer, from the bank account identified below. The withdrawal for the initial premium payment will occur only if and when the application(s) is/are approved for issue by United of Omaha.

By signing below, I/We authorize renewal premiums to be automatically paid to United of Omaha, by electronic fund transfer, from the bank account identified below and on the date specified below. I/We understand and agree that these authorized withdrawals from the bank account for premium payments will continue until this authorization is cancelled in writing.

If Monthly Bank Service Plan, complete information below **OR** attach a voided check:

Routing Number and Transit Number (9-digit number)_____

Account Number_____

Name as shown on account_____
First Initial Last

_____
Authorized Signature as shown on account

Social Security Number of Payor _____ – _____ – _____

Specify the date renewal premiums will be withdrawn (1st through the 28th of each month)_____

Section F PLEASE READ AND SIGN

Agreement:

I, the Undersigned, and the undersigned Producer(s), certify that we have read the completed application, or have had it read to us, and agree to the following:

1. All answers in this application (a) are true and complete to the best of my knowledge and belief; (b) will be relied on to determine insurability; and (c) which are incorrect or misleading, may void this application and any issued policy effective the issue date.
2. Except for coverage provided under the terms of a Conditional Receipt, if issued, the life insurance policy applied for will not take effect until it is issued by us and all of the following requirements are met: (a) the policy is delivered to and accepted by the policyowner without a change in the insurability status of the Proposed Insured; (b) the first full premium has been paid according to the mode of payment specified in the application; (c) the Proposed Insured is still alive.
3. In no event will benefits be paid for the same loss under both a Conditional Receipt and any policy issued from this application.
4. If the Applicant is other than the Proposed Insured, the Applicant will own the policy.
5. No Producer can: (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
6. REQUESTED POLICY ISSUE DATE (if applicable). _____

Continued on next page

Section F PLEASE READ AND SIGN

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.

If applying for Whole Life Express: I have received the MIB, Inc. Pre-Notice, the Notice of Information Practices, and a Life Insurance Buyer's Guide before completing this application.

I approve the answers to the questions in this application as recorded.

I have read and understand the Agreement Section.

Signed at: _____
City State

_____ Date: _____
Signature of Proposed Insured (Age 15 and Older)

_____ Date: _____
Signature of Parent or Guardian (if Proposed Insured under age 15)

_____ Date: _____
Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)

Producer Statement:

In addition to the above, by signing below, I/we, the Producer(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

Do you, the Producer(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy and/or annuity contract? ..... ☐ **Yes** ☐ **No**

Has the Proposed Insured 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 either question is answered "Yes," fulfill all state and company requirements.)

_____	_____	_____
Signature of Producer #1	Production Number	Date
_____	_____	_____
Signature of Producer #2	Production Number	Date

_____	_____	_____
Print Producer #1 Name	Print Producer #2 Name	Agency Name

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company

MICHIGAN AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

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

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and any providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental or physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug or alcohol use and other information such as finances, occupation, general reputation and insurance claims information. The personal information may be the entire medical record.

I authorize Medical Persons and Entities 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 Mutual of Omaha Insurance Company or its affiliated companies (Mutual).

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 Mutual 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.

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 this authorization and that a copy is as valid as the original.

Applicant 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 applicant. A completed and signed application will become part of each applicant'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

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 $50,000 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)

IMPORTANT DOCUMENTS

Client Forms

As part of the application process, the applicant has signed multiple forms. Applicant copies of those forms and client notifications on the following pages are to be given to the applicant.

Producer: Conditional Receipt

The applicant copy of the Conditional Receipt must be submitted to the Home Office and is not to 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 $50,000 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)

United of Omaha Life Insurance Company – 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, where applicable. You also have the right to seek correction of personal information you believe to be inaccurate. In the event of an adverse underwriting decision, our Company will provide in writing the specific reason for the underwriting decision.

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.

L8303

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, Inc., 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, Inc. Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information is: 50 Braintree Hill Park, Suite 400, Braintree, 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, Inc. may be obtained on its website at www.mib.com.

L7941

GIVE THIS NOTICE TO THE APPLICANT