



NEW BUSINESS MEMO

TERM LIFE

Telephone: 800-428-3001

Regular Mail:

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

Overnight Mail:

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

FAX Number:	317-692-7711	_____ # pages including cover
Agt Name:	_____	Agt # _____
Agt Phone:	_____	Agt Fax: _____
Agt Email Address:	_____@_____._____	

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

Street _____ City _____ State _____ Zip Code _____

Did you personally see all persons proposed for insurance, read each question to the proposed insured and record their answers?
 Yes No

If No, how was the application taken? Solicited by: Mail Telephone Internet
 Fax or Other _____

We conduct random Personal History Interviews. If we conduct a PHI with your client, what is the best time to reach the client?

Home phone (____) _____ available days? Yes No
 Business phone (____) _____ available days? Yes No
 Cell phone (____) _____ available days? Yes No

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

Special Instructions you want us to know: _____

- ### Application Completion "Tips"
1. A "yes" answer to a question on the application is not an automatic decline if it is a minor health condition. Include full details in Section 11 for underwriting consideration.
 2. Make sure to use the app with the correct state variations
 3. If Child Rider is requested, submit application 200-359
 4. If the first premium is going to be drafted from the client's bank account, *provide a copy of a voided check!* Otherwise, the case will be unnecessarily delayed
 5. Print legibly in English
 6. Keep original app until policy is issued
 7. Keep fax confirmation message that fax was successful

MAIL POLICY TO: Applicant Agent

Term Life Insurance Application

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

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

2. Employer/Occupation/Duties/How Long There

3.a. Primary Beneficiary Name		Relationship	Age
3.b. Contingent Beneficiary Name		Relationship	Age
4.a. Owner Name		Relationship	Social Security Number
Owner Street Address		City	State Zip Code
4.b. Contingent Owner Name		Relationship	Social Security Number

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

6.a. Plan of Insurance <input type="checkbox"/> Express Issue Term+ <input type="checkbox"/> Premier 20 <input type="checkbox"/> Premier 30 <input type="checkbox"/> Express Issue Term 30 <input type="checkbox"/>		6.b. Insurance Amount: \$_____ (not to exceed \$100,000) Insurance amounts up to \$150,000 are allowed under the following conditions: • Issue ages must be 18-45. • Proposed insured must submit proof of mortgage balance equal to or greater than the insurance amount being applied for.		
6.c. Accidental Death Benefit <input type="checkbox"/> \$	6.d. Waiver of Premium <input type="checkbox"/>	6.e. Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Qtrly. <input type="checkbox"/> PAC Modal Premium Amount \$		

7. Will this insurance replace or change any other insurance policies or annuities? Yes No If "Yes," please provide the complete details of the insurance to be replaced, including amount, company and plan of insurance in Number 11., and complete any necessary replacement forms.

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

9. Name and Address of Family Physician (Required)

10.a. In the past 5 years, have you been diagnosed or treated for, or are you currently under treatment for: Alzheimer's Disease, Schizophrenia, Bipolar Disorder, any form of Cancer (other than Basal Cell skin cancer), Heart or Circulatory Disorder (except controlled hypertension), Stroke, Kidney disease, Liver disease (including hepatitis B & C), any Lung Disease (except mild asthma not requiring daily medication), Diabetes requiring insulin treatment, ALS (Lou Gehrigs Disease), Sickle Cell Anemia, SLE (Systemic Lupus Erythematosus) or other neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years) or surgery for any Heart or Circulatory Disorder (except varicose veins) or transplant of any organ or have you ever tested positive for the AIDS virus or been diagnosed or treated, or recommended for treatment for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any other immune disorder?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you currently receive kidney dialysis or require oxygen use or do you require assistance to eat, bathe, dress or take your own medication, or in the past 2 years have you been diagnosed as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.); or are you currently disabled or been disabled in the last six months, or at any time during the last six months been unable to mentally or physically complete 30 hours per week of active employment?	<input type="checkbox"/>	<input type="checkbox"/>

Details to any questions, add to the next page.

c. Are you currently confined to a Hospital, Nursing Home, Mental Facility or Hospice; or have you been hospitalized two or more times in the past twelve months; or do you now participate in, or do you have plans to participate in any hazardous sport or aviation; or have you been declined or postponed for Life or Health Insurance in the past two years?	YES NO <input type="checkbox"/> <input type="checkbox"/>
d. In the past 10 years have you been convicted of a felony; or in the past 5 years have you been treated for, been advised to have treatment for or excessively used alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while intoxicated, or had your drivers license suspended or revoked? (If yes to driving questions, provide Drivers License Number _____ State _____.)	 <input type="checkbox"/> <input type="checkbox"/>

11. Details of "Yes" answers to any Questions:			
Dates	Name and Address of Physician	Diagnosis	Treatment

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

I declare that I have read and received a copy of the Fair Credit Reporting Act/Medical Information Bureau Notice.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or the Medical Information Bureau or other organization, institution, or person, that has any records or knowledge of me or my dependents or our health, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I understand that I am giving permission to release medical information which may include treatment of physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or HIV, AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen; I authorize that test for underwriting purposes.

A photographic copy of this authorization shall be as valid as the original. This release may be used for any legitimate insurance purpose.

*****WARNING*****

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud, which is a crime.

\$ _____ paid with application.

I acknowledge receipt of the Terminal Illness Accelerated Benefit Disclosure Statement with a numerical illustration showing the effect of the accelerated benefit on the policy face amount.

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

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

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

I certify that I have provided the proposed insured a copy of the Terminal Illness Accelerated Benefit Disclosure Statement and a numerical illustration.

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail _____

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

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

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

Draft my account for the first premium (initial premium may be drafted upon receipt of this application)

Monthly Draft Date for Subsequent Drafts: _____

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

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

TO: _____ Bank _____ Bank Address _____

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

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

Account No. _____ Date _____ Bank signature of Premium Payor _____

PLEASE DETACH AND GIVE TO APPLICANT

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

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

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

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

RECEIPT

Received from _____ The sum of \$ _____

Being the 1st premium of _____ mode

Type of proposed insurance _____ Amount of proposed insurance \$ _____

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

Dated at _____ on _____ Month _____ Day _____ Year

Agent Signature _____

FAIR CREDIT REPORTING ACT/MEDICAL INFORMATION BUREAU NOTICE

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

Information regarding your insurability will be treated as confidential. United Home Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to the MEDICAL INFORMATION BUREAU, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

United Home Life Insurance Company or its reinsurer(s) may also release information in its file for fraud-prevention purposes only, to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Terminal Illness Accelerated Benefit Disclosure Statement

Benefits paid under this option may be taxable. If so, the Owner or Beneficiary may incur a tax obligation. As with all tax matters, a personal tax advisor should be consulted to assess the impact of this benefit. Additionally, payment of an Accelerated Death Benefit may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

Description of Benefits

This Benefit provides you with the right to access the Death Benefit (discounted at interest for one year)* on the life of the Insured if the Insured is diagnosed with a life expectancy of twelve (12) months or less.

There is no additional premium charge for the Terminal Illness Accelerated Benefit Rider.

Effect on the Policy

When the accelerated benefit is paid, the policy terminates.

Example

This example is for illustration only, uses a \$100,000 policy and an interest rate of 7%.* **The amounts shown are not based on your specific policy.**

Accelerated Benefit Payment Amount equals the Death Benefit discounted at interest for one full year.

Death Benefit	\$100,000.00
Less 7%	<u>6,542.06</u>
Accelerated Benefit	\$ 93,457.94

*The interest rate used to discount this benefit is defined in Section A of your Terminal Illness Accelerated Benefit Rider.



Authorization for Release of Medical Information

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

This authorization complies with the HIPAA Privacy Rule.

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

_____/_____/_____
Date of Birth

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

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

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

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

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

Signature of Proposed Insured/Patient or Personal Representative

Date

Description of Personal Representative’s Authority or Relationship to Patient