



United Home Life Insurance Company

PREMIER 20 APPLICATION

Introducing a term life insurance policy with guaranteed rates for 20 years and guaranteed cash values.



Five important points to remember about the *Premier 20* Life Insurance policy:

- Provides a guaranteed level death benefit.
- Provides guaranteed cash values. The cash value at the end of the 20th policy year is equal to 20 times the annual premium.
- Provides guaranteed renewable protection to the policy anniversary nearest your 95th birthday.
- Provides for a built-in terminal condition benefit at no additional charge (if approved in your state).
- No Medical Exams or Blood Tests required.

United Home Life Insurance Company

P.O. Box 7192

Indianapolis, IN 46207-7192

1-800-428-3001

| 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 | | Are you currently at work? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | |
| Address | Street | City | | State | Zip Code | Phone Number | | | | | | | | | | | | | | | | | | | | | |
| Employer/Occupation/Duties/How Long There | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Beneficiary Name | | | | Relationship | | Age | | | | | | | | | | | | | | | | | | | | | |
| Contingent Beneficiary Name | | | | Relationship | | Age | | | | | | | | | | | | | | | | | | | | | |
| Owner Name | | | | Relationship | | Social Security Number | | | | | | | | | | | | | | | | | | | | | |
| Owner Address | | Street | City | | State | Zip Code | | | | | | | | | | | | | | | | | | | | | |
| Contingent Owner Name | | | | Relationship | | Social Security Number | | | | | | | | | | | | | | | | | | | | | |
| Billing Address | | Street | City | | State | Zip Code | | | | | | | | | | | | | | | | | | | | | |
| Secondary Addressee (For Past Due Notice) | Name | | Street | | City | State | Zip Code | | | | | | | | | | | | | | | | | | | | |
| Insurance Amount: \$ _____ (not to exceed \$100,000) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Insurance amounts up to \$150,000 are allowed under the following conditions: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <ul style="list-style-type: none"> • 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accidental Death Benefit <input type="checkbox"/> | Plan of Insurance | Waiver of Premium <input type="checkbox"/> | Modal Premium: <input type="checkbox"/> Annual <input type="checkbox"/> Qtrly. <input type="checkbox"/> Semi-Annual <input type="checkbox"/> PAC | | | | | | | | | | | | | | | | | | | | | | | | |
| \$ | ■ Premier 20 | | Modal Premium Amount \$ | | | | | | | | | | | | | | | | | | | | | | | | |
| Will this insurance replace or change any other insurance policies or annuities? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the complete details of the insurance to be replaced, including amount, company and plan of insurance and complete any necessary replacement forms. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Has the proposed insured used nicotine in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name and Address of Family Physician (Required) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. In the past 5 years, have you been diagnosed or treated for Alzheimer's Disease, internal cancer or melanoma, leukemia, heart attack, stroke, kidney disease (including dialysis), liver disease, or any lung disease or Chronic Obstructive Pulmonary Disease, insulin dependent diabetes, alcohol or drug abuse or addiction, or surgery for any heart or circulatory disease (except varicose veins), or transplant of any organ? | | | | | | YES | NO | | | | | | | | | | | | | | | | | | | | |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| 2. In the past 2 years, have you been diagnosed with a terminal illness (an illness that would be expected to cause death within 2 years); been confined (or currently confined) to a Hospital, Nursing Home, Mental Facility, or Hospice more than two times; 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? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| 3. In the past 10 years have you been convicted of a felony; or in the past five (5) years have you been convicted of operating a vehicle while intoxicated, or had your drivers license suspended or revoked? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| 4. 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? | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | |
| 5. Details of "Yes" answers to Questions 1-4: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"> <thead> <tr> <th>Dates</th> <th>Name and Address of Physician</th> <th>Diagnosis</th> <th>Treatment</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> | | | | | | | | Dates | Name and Address of Physician | Diagnosis | Treatment | | | | | | | | | | | | | | | | |
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I hereby apply for the insurance indicated above and I am submitting the first premium. The statements on this application are true to the best of my knowledge and belief. I understand coverage will not become effective until the first premium is paid and the policy is delivered to the owner.

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 for up to two (2) years from the date the contract is issued.

*****WARNING*****

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

\$ _____ paid with application.

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

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.

X _____ X _____
Printed Agent Name Agent's Signature

Agent Code _____ Agent's E-Mail _____

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

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
*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.

200-413 7-03 (PA)

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.

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

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

Draft Date: _____

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.

_____ Bank signature of Premium Payor

Account No. _____

Date _____

PLEASE DETACH AND GIVE TO APPLICANT

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 Bureau company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. (Over)



Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal FAIR CREDIT REPORTING ACT. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

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

UNITED HOME LIFE INSURANCE COMPANY

TERMINAL ILLNESS ACCELERATED BENEFIT

DISCLOSURE STATEMENT

Benefits paid under this benefit 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.

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 |

I ACKNOWLEDGE RECEIPT OF THIS DISCLOSURE

Signature of Agent

Date

Signature of Owner

Date

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



**PRE-AUTHORIZED CHECK
INITIAL WITHDRAWAL AGREEMENT**

As an applicant for insurance from United Home Life (UHL) on the life of _____, I agree that:

1. I want the premiums due on this insurance withdrawn from the account I have designated in the "Authorization to Honor Checks Drawn..." section signed with this application; and
2. I specifically want the first premium for this insurance withdrawn from that account; and
3. I understand that the first premium payment, in the amount indicated in the Modal Premium section of the application, will be drafted from the designated account within two (2) business days of the approval of the application by UHL; and
4. I understand that, unless the debit entry is dishonored, the policy will be effective on the date it is issued by UHL, and that no insurance will be provided on any conditional basis; and
5. I hereby release UHL from any liability by reason of dishonor of any withdrawal.

Signature of Depositor _____ Date ___/___/_____

United Home Life Insurance Company
P.O. Box 7192
Indianapolis, IN 46207-7192
800-428-3001



**FAXED APPLICATION –
INITIAL BANK WITHDRAWAL FOR 1ST PREMIUM PAYMENT**

This method of initial premium payment precludes the need to collect money from your client at point of sale. It allows for the first premium payment to be made by a debit from the client's bank account within two (2) business days of UHL's approval of the application

Instructions to Agents:

1. Clients' modal premium choice must be PAC
2. A voided check (or savings account deposit slip) must be included with the application. If your client selects *savings account*, make sure premium can be drafted from the client's bank. Some banks don't allow PAC withdrawals from savings.
3. Telephone number of Financial Institution...in case there are problems.
4. The AUTHORIZATION TO HONOR CHECKS DRAWN... section of the application must be completed and signed by the client.
5. If the client elects a specific monthly premium draft date (between 1st and 28th), it can be indicated under the signature of Premium Payor in the AUTHORIZATION TO HONOR CHECKS DRAWN... section; *however, the initial premium will not necessarily be drawn on that date. It will be drawn within 2 business days of the application approval.*
6. If the agent/client specify an incorrectly calculated Modal Premium Amount on the application, we'll do the following:
 - a. If the specified amount is *more* than the monthly PAC deduction, we'll draft the amount upon approval of the application and notify you;
 - b. If the specified amount is *less* than the monthly PAC deduction; we will *not* draft the amount and will not approve the policy. Instead, we will notify you for instructions.
7. If the initial draft is **returned to us because of insufficient funds or a closed account**, we will notify you for action in an effort to keep the case in-force.

Call us with your questions: 800-428-3001 (x-7724)