Always Include the cover page for both term & whole life products with UHL

United Home Life Insurance Company
Simplified Products - Faster Results

FINAL EXPENSE
WHOLE LIFE

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

FAX Number: 317-692-7711
Telephone: 800-428-3001

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

_____ # pages including cover

Fax only once.

Agt Name: Brad Smith Agt #: L0001111111

Agt Phone: (423) 555-5555 Agt Fax: _____

Agt Email Address: brad.sfg@gmail.com

How do you prefer to be notified if we should need any underwriting requirements?

☒ E-Mail ☐ Fax ☐ US Mail

Street _____ City _____ State _____ Zip Code _____

Proposed Insured's Name: John D. Smith

Do you personally know the proposed insured? ☐ Yes ☒ No

Have you written insurance on the proposed insured in the past three (3) years? ☐ Yes ☒ No

Did you personally see all persons proposed for insurance and personally view a photo ID (driver's license, passport) of the proposed owner and/or insured? ☒ Yes ☐ No

If No, how was the application taken?

Solicited by: ☐ Mail ☐ Telephone ☐ Internet ☐ Fax ☐ Other _____ (Explain)

Did you identify any unusual behavior or suspicious activity by the proposed owner or insured? ☐ Yes ☒ No

If Yes, please explain. _____

Special Instructions you want us to know: _____

MAIL POLICY TO: ☐ **Owner** ☒ **Agent**

Check the box to where you would like the policy sent. We suggest agent, and to deliver the policy!

Personal History Interviews (PHIs):

Option 1 (preferred option) Know Before You Go: You, the agent, initiate a point-of-sale (POS) interview from your client's home by calling **866-333-6557**. Tell the operator this interview is for UHL and the Modified Death Benefit Whole Life (graded benefit), Deluxe or Premier plan and hand the phone to your client **(Be specific as to which product you want so that only the plan-specific questions will be asked).** During the call, the interviewer will conduct MIB and Prescription Drug searches to better determine your client's suitability for the product you've selected. Upon completion of the interview, and based on the client's answers to the questions and results of the database searches, the interviewer will tell you whether or not the application should be sent to the Home Office.

Complete the phone interview in the home with the client when taking the app

Did you complete a Point of Sale Personal History Interview with your client? ☒ Yes ☐ No

Option 2: UHL will order the PHI after you've completed the application with your client and submitted it to the Home Office. A PHI is required for all Modified Death Benefit Whole Life, Deluxe and Premier sales, regardless of face amount. What is the best time to reach this 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 _____.

Important Reminders

1. **UHL WHOLE LIFE PRODUCTS USE THE "AGE LAST BIRTHDAY" METHOD FOR DETERMINING THE AGE OF THE PROPOSED INSURED FOR INSURANCE PURPOSES.**
2. Print legibly in English.
3. Keep original app until policy is issued.
4. If faxing, keep fax confirmation message that fax was successful.
5. If the replacement question is answered "Yes," ensure that the applicable replacement form(s) has been completed and included (if required).
6. Cash is not permitted for the payment of premium(s).
7. The Fair Credit Reporting Act/MIB Notice and, if applicable, the Notice of Insurance Information Practices must be given to the proposed insured. These documents must also be provided to any applicant who completes the Know Before You Go (point-of-sale) PHI process, regardless of whether an application is written or not.
8. **Appointment regulations vary by state. A few states require appointment before an application can be taken; several others require appointment within a period of days after an application is written. Contact the Home Office or check with your state to ensure compliance prior to taking an application.**

Application for Life Insurance

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

SECTION 1 – Proposed Insured

Last Name	First Name	Middle Initial
Smith	John	D.

Date of Birth (M-D-Y)	State of Birth	
05-05-1955	TX	☒ Male ☐ Female

Marital Status	Height	Weight
M	6'0"	200

Social Security Number: 987-65-4321

U.S. Citizen: ☒ Yes ☐ No *If no, give immigration status/type of visa:*

If no, take a pic of their visa/green card and get the id number

Street Address: 123 Easy St.

City	State	Zip Code	Phone Number
Dallas	TX	75001	(555) 555-5555

Employer/Occupation/Duties/How Long There **(Required for Proposed Insureds under age 65)**

Accounting Firm, Inc.

Put their position and how long they have been there

Billing Street Address	City	State	Zip Code

Secondary Addressee (For Past Due Notice)	Name	Street	City	State	Zip Code

SECTION 2 – Ownership (Complete only if Owner is other than Proposed Insured)

Owner Name	Relationship	Social Security Number

Owner Street Address	City	State	Zip Code

Contingent Owner Name	Relationship	Social Security Number

SECTION 3 – Beneficiary(ies)

Primary Beneficiary Name	Relationship	Age
Mary Smith	Wife	55

Contingent Beneficiary Name	Relationship	Age

check this box in order to be paid even if a change has to be made on the policy or product

SECTION 4 – Plan of Insurance

Plan of Insurance ☐ Modified Death Benefit Whole Life ☐ Express Issue Deluxe ☒ Express Issue Premier

Face Amount: $ 15,000

☒ Check here if you are willing to accept any product listed in this section for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit in the first 2 years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.

If the Face Amount shown above is $10,000 or greater and the product issued is the Modified Death Benefit Whole Life, the following riders will be attached to the policy: Identity Theft Waiver of Premium Rider, Hospital Stay Waiver of Premium Rider and Common Carrier Accidental Death Benefit Rider.

☐ Accidental Death Benefit Rider (not available with Modified Death Benefit WL) $_____

SECTION 5 – Payment Information

Modal Premium: ☐ Annual ☐ Semi-Annual ☐ Qtrly. ☒ PAC* Modal Premium Amount $ 98.20

$ 98.20 paid with application.

Always check PAC unless they are paying annually for the full yr which with UHL would require them to write out a check to UHL for the annual payment

***If selected, bank information on Page 5 must be fully completed.**

SECTION 6 – Other Insurance

Do you have any existing life insurance policies or annuity contracts? ☐ Yes ☒ No

If "Yes," please complete any necessary replacement forms.

Only mark yes if they own insurance or an annutiy outside of work

SECTION 7 – Nicotine Use

Has the Proposed Insured used nicotine in any form in the past 12 months? ☐ Yes ☒ No

answer accordingly

SECTION 8 – Physician Information

Name and Address of Family Physician **(Required)**	Family Physician Telephone Number **(Required)**
Dr. David Scott 1000 Medical Ln. Dallas, TX 75001	(800) 555-5555

Must have all the questions answered according to the product you are applying for. Example: If you are applying only for the Deluxe product, you do not need to answer the questions in the Premeier section etc.

SECTION 9 – Medical Questions

PART A – MODIFIED DEATH BENEFIT WHOLE LIFE – COMPLETE PART A ONLY

If any question in Part A is answered "Yes", you are not eligible for Modified Death Benefit Whole Life.

A. Do you currently receive kidney dialysis or require oxygen use or have you received or been told that you need an organ transplant or 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.)	☐ Yes ☒ No
B. Do you require assistance to feed, bathe, dress or take your own medication or are you currently confined to a hospital, nursing home, mental facility, hospice, or require home health nursing care?	☐ Yes ☒ No
C. 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
D. **In the past twelve (12) months:**	
1. Other than for temporary or minor conditions, have you been hospitalized two or more times?	☐ Yes ☒ No
2. Other than preventive, maintenance or risk lowering medications prescribed, have you been treated for or diagnosed with any cancer (other than Basal Cell skin cancer), heart attack, stroke, or had heart surgery (including angioplasty)?	☐ Yes ☒ No
3. Have you used any illegal drugs, been treated for or advised to have treatment for drug abuse?	☐ Yes ☒ No

PART B - EXPRESS ISSUE DELUXE – COMPLETE PARTS A & B ONLY

If any question in Part B is answered "Yes", you are not eligible for Express Issue Deluxe. Submit the case as Modified Death Benefit Whole Life.

A. **In the past 2 years:**	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Alzheimer's Disease or Dementia?	☐ Yes ☒ No
b. Any form of Cancer (other than Basal Cell skin cancer) or Brain Tumor?	☐ Yes ☒ No
c. Other than preventive, maintenance or risk lowering medications prescribed, have you been diagnosed or treated for Heart or Circulatory Disorder (except controlled hypertension) or Stroke?	☐ Yes ☒ No
d. Had surgery for any Heart Disorder (including angioplasty) or Circulatory Disorder (except varicose veins)?	☐ Yes ☒ No
e. Sickle Cell Anemia or Kidney Disease (including dialysis) or Liver Disease (including hepatitis B & C)?	☐ Yes ☒ No
f. Lung Disease (except controlled, mild asthma not requiring any hospitalization in the past 2 years)?	☐ Yes ☒ No
g. ALS (Lou Gehrig's Disease) or Neurological disorders (except for controlled seizure disorder with no seizures in the past 2 years)?	☐ Yes ☒ No
2. Have you been advised by a medical professional to have any tests, surgery, treatment, or further medical evaluation that have not been performed or do you have any medical test results pending?	☐ Yes ☒ No
3. Have you excessively used, been treated for or been advised to have treatment for alcohol or drug abuse?	☐ Yes ☒ No
B. **In the past 10 years** have you been convicted of a felony or currently have pending charges for a felony; or currently on parole from a felony conviction?	☐ Yes ☒ No

PART C - EXPRESS ISSUE PREMIER – COMPLETE PARTS A, B, & C

If any question in Part C is answered "Yes", you are not eligible for Express Issue Premier. Submit the case as Express Issue Deluxe.

A. **In the past 2 years:**	
1. Have you been diagnosed or treated for, or are you currently under treatment for:	
a. Schizophrenia or Bipolar Disorder?	☐ Yes ☒ No
b. Diabetes requiring insulin treatment?	☐ Yes ☒ No
c. SLE (Systemic Lupus Erythematosus)?	☐ Yes ☒ No
2. Have you been convicted of operating a vehicle while intoxicated, or had your driver's license suspended or revoked?	☐ Yes ☒ No
3. Have you been declined or postponed for Life Insurance?	☐ Yes ☒ No
B. If under age 65, are you currently disabled, or been disabled in the last six months or at any time during the last six months received any disability compensation or been mentally or physically unable to complete 30 hours per week of active employment?	☐ Yes ☒ No
C. Do you now participate in, or do you have plans to participate in any hazardous sport or aviation?	☐ Yes ☒ No

SECTION 10 – Agreement/Acknowledgment

I hereby apply for the insurance indicated above and I am submitting the first premium. I have read (or have had read to me) all statements and answers recorded on this application, and 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 later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

I declare that I have read and received a copy of the Fair Credit Reporting Act/MIB, Inc., Notice.

*****WARNING*****

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I hereby certify under penalties of perjury, that the tax identification number provided is true, correct and complete.

SECTION 11 – Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc. ("MIB"), or other organization, institution, or person, that has any records or knowledge of me or my dependents, if they are to be insured, or our health, to give the United Home Life Insurance Company ("UHL") or its reinsurer(s) any such information. UHL may also disclose such information to reinsurers, MIB, persons or entities performing business, professional or insurance functions for UHL or as may otherwise be legally allowed. I further authorize UHL or its reinsurer(s) to make a brief report of my personal health information to MIB. 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 UHL 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 of my signature below. I have a right to receive a copy of this authorization.

SECTION 12 – HIPAA Authorization

This authorization complies with the HIPAA Privacy Rule.

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 and its agents, employees, and representatives. United Home Life Insurance Company may disclose such information to reinsurers, the MIB, Inc., persons or entities performing business, professional or insurance functions for United Home Life Insurance Company or as may otherwise be legally allowed. 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 24 months following the date of my signature below, and a copy, image, or facsimile 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 have a right to receive a copy of this authorization.

Always mark this box, some people miss it

SECTION 13 – Disclosure Acknowledgement

☒ **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. (This benefit is not available with the Modified Death Benefit Whole Life plan.)**

SECTION 14 – Signatures

Signature applies to Sections 1 through 13. Review before signing.

Dated at Dallas (City), TX (State), this 14 day of May (Month), 2014 (Year)

X John D. Smith

Signature of Proposed Insured or personal representative

Description of personal representative's authority to act

Signature of Owner (If other than Proposed Insured)

Dont miss this box

If they have insurance that is NOT with work, something that they own personally, then you will need to mark does, and fill out the replacement form.

THE FOLLOWING SECTION MUST BE COMPLETED BY THE AGENT.

To the best of my knowledge and belief the applicant does ☐ does not ☒ have any existing life insurance policies or annuity contracts.

☒ I certify that I have provided the Proposed Insured a copy of the Terminal Illness Accelerated Benefit Disclosure Statement and a numerical illustration.

X Brad Smith
Printed Agent Name

X
Agent's Signature

~~Agent Code~~ -> L0001111111 Agent's E-Mail brad.sfg@gmail.com

Agent: Phone # (423) 555-5555 Fax# _____ License Identification Number (TX) 412214
State

If you do not have a producer number yet, put in your SS # and write pending next to it. In the State of TX ,NM, PA,LA, & GA you MUST be pre-appointed with UHL to write an application and will NEED to have your agent number prior to submitting your application. If you live in one of those states, please contact your mgr to be pre-appointed if you plan on writing an application with UHL

This is your State specific license number that you recieved when you got your license.

Always mark this box as this will indicate that the first months premium willl be drafted when the app is submittted, you can put in a date if you would like for the monies to be withdrawn the FOLLOWING month, but most of the time we do that on the delivery of the policy. If for some reason you have to delay them drafting immediatley, speak to your manager b/fore submitting and _____ the correct box.

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

The initial modal premium **must** be quoted in Section 5 of the application.
We do not accept debit or credit cards.

Please select ONLY one option. Include a copy of voided check for bank draft.

☒ Draft my account for the first premium (initial premium may be drafted immediately upon submission of this application). Please draft subsequent premiums on the _____ day of each month.

☐ Draft my account for the first premium on: _____ . All subsequent drafts will occur on this same day each month.

☐ *Do NOT draft my account for the first premium. The initial premium is attached, is being mailed, or will be collected on* delivery. **Please make check or money order payable to United Home Life Insurance Company. Do not leave Payee blank or make it payable to the agent.** Please draft subsequent premiums on the _____ day of each month.

The policy may be placed on direct quarterly mode temporarily if we do not receive complete bank information or if there is a difference in premium quoted.

I understand that my policy will not be effective until the later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

Bank Name Chase Bank Bank Address Dallas, TX

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 understand that I am personally liable for overdraft fees charged on said account if funds are not available at the designated date of withdrawal. 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 Number: 0042001578 ☒ Checking ☐ Savings Routing Number: 001230045 6

Premium Payor's Printed Name: John D. Smith Relationship to Insured: Self or person paying

Signature of Premium Payor: (X) John D. Smith Date: 5/14/14

In the event that a pre-printed void check or bank statement is not available, please complete the following information for account verification:

Financial I: John D. Smith Check _____

Address: _____

I have per:

Agent Nar

Agent Sig:

VOID

200-719A 12-12 (AR)

You would fill in the above section if you were unable to collect a voided check!

I always have the client sign this form. You would mark yes on the first line ONLY if they have any life insurance or annuties that are outside of work. Ques #1 and #2 are Always no. If replacing a policy, ask your manager Before filling this form out,

UNITED HOME LIFE INSURANCE COMPANY
P.O. Box 7192
Indianapolis, IN 46207-7192
Phone: (317) 692-7979 Fax: (317) 692-7711

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions.

Do you have any existing insurance policies or annuities? __x__YES or **____x__NO**

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? _____YES ____x__NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? _____YES ____x__NO

   If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (including the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	Insurer Name	Contract Or Policy #	Insured Or Annuitant	Replaced (R) Or Financing (F)
1.	leave all this info blank			
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because Leave Blank

I certify that the responses herein are, to the best of my knowledge, accurate:

John Smith
Applicant’s Signature and Printed Name

May 14, 2014
Date

Brad Smith
Producer’s Signature and Printed Name

May 14, 2014
Date

I do not want this notice read aloud to me. __(Applicants must initial only if they do not want the notice read aloud.)

This form is filled out and left with the customer

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 later of: the date it is issued by the company as applied for and the premium paid; or the date of my written acceptance of the policy if issued other than applied for and the premium paid.

RECEIPT

Received from John Smith The sum of $ 98.20

Being the 1st premium of Montly mode

Type of proposed insurance Mortgage payment protection Amount of proposed insurance $ 1 yr mortg pymnts

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

Dated at Dallas TX on May (Month) 15 (Day), 2014 (Year)

Agent Signature

FAIR CREDIT REPORTING ACT/MIB, INC., 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 MIB, Inc., 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. 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 office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, 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 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

IMPORTANT INFORMATION FOR VERIFYING IDENTIFICATION

To help fight the funding of terrorism and money-laundering activities, Federal law requires all financial institutions (including insurance companies) to obtain, verify and record information that identifies each person who engages in certain transactions. This means that when you apply for permanent life insurance or annuity products we will verify your name, residential address, date of birth, and other information that allows us to identify you. We may also ask to see your driver's license or passport.

Terminal Illness Accelerated Benefit Disclosure Statement

(This benefit is not available with the Graded Death Benefit Endowment or Express Issue Whole Life plans.)

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 $50,000 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	$50,000.00
Less 7%	3,271.03
Accelerated Benefit	**$ 46,728.97**

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