

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefits received under the rider may be taxable. Receipt of the benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting the benefit.

DISCLOSURE FOR TERM LIFE INSURANCE POLICIES

If you are applying for term life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Limited Life Expectancy Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

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

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

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

DISCLOSURE FOR UNIVERSAL LIFE INSURANCE POLICIES¹

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Limited Life Expectancy and Chronic Condition Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

While the rider is in force and if the Insured is diagnosed as having a Limited Life Expectancy or as having a Chronic Condition, you may elect to receive an accelerated death benefit. Limited Life Expectancy means a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date on the statement of proof of Limited Life Expectancy. A physician must sign and date the statement of proof of Limited Life Expectancy. A Chronic Condition means that the Insured is unable to perform at least two Activities of Daily Living and has been confined to a Nursing Home for 90 consecutive days or more. A physician must certify that the Insured has a Chronic Condition.

The amount available for an accelerated death benefit depends on your policy's current death benefit and the provisions of your policy. The aggregate total of all elections may not exceed \$250,000. You may elect to receive the Chronic Condition benefit more than once. In contrast, you may elect to receive the Limited Life Expectancy benefit only once. If you elect to receive the Limited Life Expectancy benefit, the Chronic Condition benefit is no longer available.

We will reduce the requested Chronic Condition benefit by an actuarial discount as determined by the factors in the rider. For the Limited Life Expectancy benefit, we will reduce the requested amount by 6%. We will also adjust the Limited Life Expectancy benefit and each Chronic Condition benefit by a \$100 charge and the pro-rated amount of any outstanding loans.

– continued on next page –

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The rider will terminate when the Limited Life Expectancy benefit is paid or the aggregate total of all elections reaches \$250,000. If your policy includes a Return of Premium Benefit provision, we will reduce the premium used to calculate the Return of Premium benefit by the benefit paid. We will reduce the current amount of insurance coverage, tabular value, accumulation value, surrender value, and any policy loan by the same proportion as the requested reduction in the death benefit. We will base the future premium and policy charges on the reduced amount of insurance coverage.

¹ Accelerated Death Benefit Rider not available for Single Premium Life.

Acknowledgment

I acknowledge receipt of this Disclosure Form

Applicant/Owner Signature

Date

I have provided this Disclosure Form to the Applicant

Producer Signature

Date

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



CHECKLIST FOR SUBMITTING A COMPLETE APPLICATION

Please mail application and appropriate forms to: United of Omaha Life Insurance Company,
Attn: Individual Life Underwriting, 9330 State Hwy 133,
Blair, NE 68008

ONE BASE POLICY PER APPLICATION

- Write in the product name and the amount of insurance applied for.
- If applying for any rider offering Disability Benefits, complete the supplemental application
- If applying for the Children's Rider Application - complete the supplemental application
- Complete Monthly Bank Withdrawal form if applicable
- Attach cover letter or additional information, as needed

■ ALL CHANGES SHOULD BE INITIALED BY THE APPLICANT/OWNER

- Always submit the Producer Statement and always provide client with MIB Group Inc Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Investigative Consumer Reports Notice, Summary of Rights, and Life Insurance Buyer's Guide
- Always obtain signed MIB and HIPAA authorizations
- If face amount is over \$250,000 – you will need a signed HIV consent form if your state requires this form. If your state does not require the HIV Consent form then this form will not be included in this application package.
- Submit a signed Accelerated Benefit Disclosure Form.
- Complete Conditional Receipt form. **IF A CHECK FOR THE INITIAL PREMIUM WAS NOT COLLECTED at the time of application do not complete the form.**
- If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client.

UNITED OF OMAHA LIFE INSURANCE COMPANY

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



PART 1, PAGE 1 OF 2 LIFE INSURANCE APPLICATION

PROPOSED INSURED

Proposed Insured Legal Name _____

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

Date of Birth _____ State of Birth _____ Annual Income _____

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

Legal Residence Address _____
Street _____

City _____ State _____ ZIP _____

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

Occupation/Duties _____ Employer _____

PLAN INFORMATION

Term Life Express Amount of Insurance Applied for \$ _____

TERM LIFE: 30-Year Level Term Life with 5 Year Guarantee 30-Year Level Term Life with 30 Year Guarantee
 20-Year Level Term Life with 5 Year Guarantee 20-Year Level Term Life with 20 Year Guarantee
 15-Year Level Term Life with 15 Year Guarantee

Return of Premium Term (not available for 5-Year or 15-Year Guarantee) Yes No

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

Term Riders

Disability Income Rider (not available with Return of Premium): 18 months 30 months
Disability Income Rider Monthly Benefit \$ _____

Disability Waiver of Premium Rider

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

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

PERMANENT LIFE:

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

Single Premium Life Amount of Insurance Applied for \$ _____

Permanent Life Riders

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

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

PAYMENT MODE Annual Semiannual Quarterly Monthly Bank Draft Other _____

Modal Premium \$ _____ Collected Premium \$ _____

OWNER

Complete Policyowner information if Proposed Insured is not the Policyowner

Name of Policyowner _____ Date of Birth _____

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

Citizenship Country _____ Phone No. _____

Policyowner Address _____
Street _____ City _____ State _____ ZIP _____

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

Name _____

Mailing Address _____
Street _____ City _____ State _____ ZIP _____

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

PART 1, PAGE 2 OF 2 LIFE INSURANCE APPLICATION

BENEFICIARY	Primary Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth
	_____	_____	_____	_____
	Contingent Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth
	_____	_____	_____	_____

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

OTHER COVERAGE INFORMATION	1. Has the Proposed Insured been offered cash or any other consideration for obtaining this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Are you planning to enter into a finance arrangement to pay any premium payments due under this policy? .. <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Do you intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If "Yes" to questions 1, 2 or 3, provide information in Comments section.
	4. List below all life insurance policies and/or annuity contracts on any person proposed for insurance that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt.) If none, check the following box <input type="checkbox"/> None

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

Please complete the box(es) below.
The Producer shall comply with any additional state and/or company replacement requirements.

Company	Policy or Contract Number	Face Amount	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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

UNITED OF OMAHA LIFE INSURANCE COMPANY

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



PART 2, PAGE 1 OF 2 LIFE INSURANCE APPLICATION

UNDERWRITING	If the Proposed Insured answers "Yes" to questions 1 through 7 in this section, that person is not eligible for coverage under this application.	Proposed Insured
	1. Has the Proposed Insured ever been diagnosed by a member of the medical profession or been tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Has the Proposed Insured ever (a) received care or treatment for, or (b) been advised by a member of the medical profession to seek treatment for, or (c) consulted with a health care provider regarding: (a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Heart Murmur/Valvular Heart Disease or Replacement, Cardiomyopathy, Congenital Heart Disease, Stroke/mini-stroke, abnormal heart rhythm, or Cerebral or Symptomatic Aneurysm? (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) Systemic Lupus or Scleroderma? (h) an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. In the past 12 months, has the Proposed Insured: (a) required the assistance of another person or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel or bladder problems? (b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, speech therapy, or is the Proposed Insured currently confined to any hospital or other medical facility? (c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? (d) applied for, received, or is the Proposed Insured currently receiving, disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity, fractures, spinal or back disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	4. In the past 12 months, has the Proposed Insured: (a) been advised by a member of the medical profession to have a surgical operation, diagnostic testing other than for routine screening purposes, treatment, or other procedure which has not been done? (b) consulted a member of the medical profession for chronic cough, unexplained weight loss, fatigue or unexplained gastrointestinal bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	5. In the next 2 years, will the Proposed Insured engage in any motor sports racing, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	6. In the past 10 years, has the Proposed Insured: (a) used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a member of the medical profession? (b) used unlawful drugs in any form (including cocaine, methamphetamines and hallucinogens) or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form? (c) been convicted of or incarcerated for a felony? (d) been hospitalized for high blood pressure or any mental or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	7. In the past 5 years, has the Proposed Insured been convicted of driving under the influence of drugs or alcohol, been convicted of reckless driving, or had four or more moving violations?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART 2, PAGE 2 OF 2 LIFE INSURANCE APPLICATION

UNDERWRITING

8. Is the Proposed Insured a citizen of the United States? Yes No
If "No," complete the Foreign National questionnaire.

9. Has the Proposed Insured ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy? Yes No
If "Yes," please list details below.

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

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

AGREEMENT

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

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

Signed at: _____ Date _____
 City State Mo Day Yr

Signature of Proposed Insured Age 15 and Over

Signature of Applicant/Owner/Trustee if other than Proposed Insured or if the Owner is a corporation, trust, or other entity. Include title of Signee(s).

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

Signature of Parent or Guardian if Proposed is under Age 15

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



PRODUCER STATEMENT

1. Has any person proposed for insurance informed you, the Producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? Yes No

If "Yes," give name(s) of the person(s) _____

2. Do you, the Producer(s), know or have reason to believe that the policy(ies) applied for has replaced or will replace any existing life insurance policies or annuity contracts? Yes No

3. Did you, the Producer(s), give each person proposed for insurance the MIB Group, Inc. Pre-Notice, the Notice of Information Practices and the Life Insurance Buyer's Guide and comply with all state and Company replacement requirements? Yes No If "No," please explain _____

4. I/We certify that, during an interview with the Proposed Insured, I/we asked each question exactly as written and recorded the answers provided by the Proposed Insured(s) completely and accurately. Yes No
If "No," please explain _____

5. I conducted said interview in person Yes No If "No," please explain _____

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

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

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

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

Address	From	To

Signature of Producer #1 _____ Production Number _____ Mo Day Yr

Signature of Producer #2 _____ Production Number _____ Mo Day Yr

Print or Stamp Producer #1 Name _____

Print or Stamp Producer #2 Name _____

General Agent/General Manager Name _____

General Agent/General Manager Stamp _____

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

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

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

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

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

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

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

Complete information below OR attach a voided check:

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

Account No.

Name of Payor as shown on account
First Initial

Last

ATTACH CHECK HERE

Account Holder Name	Check Number	
John Doe Street Address Town, City Zip code	Check #1234 Date: _____	
Pay to: _____ _____ Dollars		
Bank Name & Address		
Memo _____	Signed By: _____	
1:123456789:1 12345678 11* 1234 11*		
Bank Routing/ Transfer Number	Bank Account Number	Check Number (if shown at bottom, may be shown before or after the account #)

SUBMIT TO HOME OFFICE

L8240

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

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

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

I also authorize Mutual to disclose my personal information to the MIB. I understand that my personal information received by the MIB may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I may submit a claim for benefits.

If the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the information may be redisclosed without the protection of the federal privacy regulations.

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

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

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

Name(s) used for medical records (if different than the name) below: _____

Signature of Proposed Insured

Date: _____
Mo Day Yr

Signature of Spouse (If Proposed Insured)

Date: _____
Mo Day Yr

Signature of Parent or Guardian (if Proposed insured is a minor)

Date: _____
Mo Day Yr

Signature of Non-minor Child (If Proposed Insured is a Non-minor)

Date: _____
Mo Day Yr

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The benefits received under the rider may be taxable. Receipt of the benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax advisor or the Social Security Administration before requesting the benefit.

DISCLOSURE FOR TERM LIFE INSURANCE POLICIES

If you are applying for term life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Limited Life Expectancy Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

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

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

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

DISCLOSURE FOR UNIVERSAL LIFE INSURANCE POLICIES

If you are applying for universal life insurance benefits, this disclosure is a brief description of the Accelerated Death Benefit for Limited Life Expectancy and Chronic Condition Rider and its effects on your policy. This disclosure is not an insurance contract, but only a summary of the coverage provided by the rider. There is no premium or cost of insurance charge for the rider.

BENEFIT DESCRIPTION

While the rider is in force and if the Insured is diagnosed as having a Limited Life Expectancy or as having a Chronic Condition, you may elect to receive an accelerated death benefit. Limited Life Expectancy means a medical condition that, within a reasonable degree of certainty, will result in the Insured's death within 12 months or less from the date on the statement of proof of Limited Life Expectancy. A physician must sign and date the statement of proof of Limited Life Expectancy. A Chronic Condition means that the Insured is unable to perform at least two Activities of Daily Living and has been confined to a Nursing Home for 90 consecutive days or more. A physician must certify that the Insured has a Chronic Condition.

The amount available for an accelerated death benefit depends on your policy's current death benefit and the provisions of your policy. The aggregate total of all elections may not exceed \$250,000. You may elect to receive the Chronic Condition benefit more than once. In contrast, you may elect to receive the Limited Life Expectancy benefit only once. If you elect to receive the Limited Life Expectancy benefit, the Chronic Condition benefit is no longer available.

We will reduce the requested Chronic Condition benefit by an actuarial discount as determined by the factors in the rider. For the Limited Life Expectancy benefit, we will reduce the requested amount by 6%. We will also adjust the Limited Life Expectancy benefit and each Chronic Condition benefit by a \$100 charge and the pro-rated amount of any outstanding loans.

– continued on next page –

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

The rider will terminate when the Limited Life Expectancy benefit is paid or the aggregate total of all elections reaches \$250,000. If your policy includes a Return of Premium Benefit provision, we will reduce the premium used to calculate the Return of Premium benefit by the benefit paid. We will reduce the current amount of insurance coverage, tabular value, accumulation value, surrender value, and any policy loan by the same proportion as the requested reduction in the death benefit. We will base the future premium and policy charges on the reduced amount of insurance coverage.

Acknowledgment

I acknowledge receipt of this Disclosure Form

Applicant/Owner Signature

Date

I have provided this Disclosure Form to the Applicant

Producer Signature

Date

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
United World Life Insurance Company

- ATTN: Health: Mutual of Omaha Plaza, Omaha, NE 68175
 - ATTN: Life Agency: Mutual of Omaha Plaza, Omaha, NE 68175
 - ATTN: Life Brokerage: P.O. Box 2476, Omaha, NE 68103-2476
 - ATTN: True Group: Mutual of Omaha Plaza, Omaha, NE 68175
-

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are positive, you are entitled to that information. However, because a trained person should deliver that information so that you can understand clearly what the test results mean, you are required to list a physician, a local health department or a local community-based organization so that they may tell you the result, explain its meaning and provide post-test counseling.

Name of Physician/Health Care Agency _____

Address _____

You are required by law to designate to whom a positive test result shall be sent. If you do not know who to select, you may refer to the accompanying list and select the agency to whom you wish results to be forwarded.

Consent

I have read and I understand this Informed Consent Form. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of my blood and/or other bodily fluids for HIV antibodies, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date _____

Signature of Proposed Insured

Signature of Agent/Witness