Last Name	First Name	Middle Initial	Date of Birth (M-D-Y)	State of Birth	❑ Male ❑ Female

Marital Status	Height	Weight	Social Security Number	Are you currently at work? ❑ Yes ❑ 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) $	Accidental Death Benefit ❑ $	Waiver of Premium ❑	Modal Premium: ❑ Annual ❑ Qtrly. ❑ Semi-Annual ❑ PAC Modal Premium Amount $

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 and complete any necessary replacement forms.

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

Name and Address of Family Physician (Required)

	YES	NO
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?	☐	☐
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 has the proposed insured ever been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex) by a member of the medical profession, or tested positive for HIV antibodies as part of a test conducted for the purpose of obtaining insurance?	☐	☐
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?	☐	☐
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?	☐	☐

5. Details of "Yes" answers to Questions 1-4:

Dates	Name and Address of Physician	Diagnosis	Treatment

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 that my policy will be effective on the date it is issued by the company.

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, that has information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents, to give the United Home Life Insurance Company or its reinsurer(s) any such information. I acknowledge that the information obtained by this authorization will be used by United Home Life Insurance Company to determine eligibility for insurance as applied for in this application. I understand that I am giving permission to release medical information which may include treatment or physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment and/or AIDS, or AIDS-related information.

I understand that United Home Life Insurance Company may require that I submit to an HIV (HTL VIII) Screen. Prior to submitting to an HIV (HTL VIII) Screen I must be provided and sign a separate Notice and Consent for Oral Fluid and/or Blood Testing form.

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. You are entitled to receive a copy of this authorization.

WARNING

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

$ ____________________ paid with application.

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.

X ____ X ____

Printed Agent Name Agent's Signature

Agent Code ____ Agent 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.

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.

____

Account No. Date Bank signature of Premium Payor

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)