OLD MUTUAL
Financial Network

Life Insurance Application

INSTRUCTIONS

Please print on all areas of the application

1. Fill out and sign the life insurance application.
   - ❍ Make sure the ZIP code is included in the primary insured's mailing address (pg. 1).
   - ❍ Remember to fill in the beneficiary's full name and relationship to the primary insured (pg. 1).
   - ❍ Under Product Name (pg. 2), write the marketing name of the plan of insurance.
   - ❍ Remember to fill out the complete addresses and phone numbers for all doctors and hospitals (pgs. 5-6).
   - ❍ Remember to fill out the replacement question in the Agent Certification section (pg. 7).

   Submit application to:

   Mailing Address:
   OM Financial Life Service Center
   P.O. Box 81497
   Lincoln, NE 68501

   Overnight Address:
   OM Financial Life Service Center
   421 South 9th Street, Suite 222
   Lincoln, NE 68508

   NOTE: As applicants will automatically be assigned to the best underwriting class for which they qualify, it is not necessary to indicate the desired underwriting class on the application.

2. If the primary insured or owner lives in a state where one of the fraud warnings applies, fill out and sign the "Fraud Warning Notices" page (pg. 8).
3. If the primary insured or owner is applying for spousal coverage, fill in Other Insured section (pg. 1). If Children's Insurance is being applied for, use the Children's Insurance Supplement, Admin 4948.
4. Use the space following the Medical Questions for any "yes" answers. If more space is required to explain any "yes" answers or for any other reasons, fill out the "Additional Information" section (pg. 8) and sign it.
5. For Corporate/Business proposed insureds, fill out the Life Financial Supplement form, Admin 2822. Earned Annual Income is defined as net income after expenses and before taxes.
6. For bank draft payment modes, sign and date the "Bank Draft Plan: EFT Premium Authorization to My Bank" page (final page in application packet). Attach a voided check.
7. Credit card processing is available for the initial payment only. If elected, please be sure to also complete the Mode of Payment section (pg. 2) for subsequent payments.
8. If cash is paid with the application, fill out the "Life Insurance Conditional Receipt" stub (first page after application) and leave it with the applicant. Otherwise, discard it.
9. Leave the page containing the "Investigative Consumer Report Pre-Notification" and the "MIB Pre-Notification" with the applicant (second page after application).
10. All supplemental questionnaires/forms are viewable and orderable on SalesLink at www.omfn.com. Forms are available for the following:

    Motorsports; Residence & Travel; Military; Arthritis; Back Disorders; Diabetes; Growths, Cysts & Tumors; Climbing; Diving; Aviation; Parachuting; Gliding, Hang Gliding and Ultra-Lighting; Children's Insurance; Paramed Form; Reinstatement Application; and Critical Illness Coverage.

No bank guarantee. • Not FDIC/NCUA/NCUSIF insured. • May lose value if surrendered early.

Life Insurance Application (page 1 of 8)

☐ ESP ADMIN 4952

INSURER

OM Financial Life Insurance Company

PRIMARY INSURED

Name (First, M.I., Last)

Home Address

Social Security No.	Sex	Marital Status	Date of Birth	Place of Birth	Height (ft., in.)	Weight (lbs.)

Currently Employed? ❍ Yes ❍ No	Occupation and Duties	Place of Employment	Years w/ Current Employer

Earned Annual Income (from last year's W-2)	Drivers License Number and Issue State

Daytime Phone	Evening Phone	Best Time to Call	Email Address

OTHER INSURED

Name (First, M.I., Last)	Relationship to Primary Insured

Home Address

Social Security No.	Sex	Marital Status	Date of Birth	Place of Birth	Height (ft., in.)	Weight (lbs.)

Currently Employed? ❍ Yes ❍ No	Occupation and Duties	Place of Employment	Years w/ Current Employer

Earned Annual Income (from last year's W-2)	Drivers License Number and Issue State

Daytime Phone	Evening Phone	Best Time to Call	Email Address

OWNER(S)

(UNLESS OTHERWISE NOTED, THE OWNER WILL BE THE PRIMARY INSURED.)

Name (First, M.I., Last)	Relationship to Primary Insured

Home Address

Home Phone	Email Address

Birth Date	Social Security No. or Tax I.D. No.

BENEFICIARY DESIGNATION - Primary Insured Coverage

FOR EACH BENEFICIARY, LIST FULL NAME, RELATIONSHIP TO PRIMARY INSURED AND % SHARE.

Primary Beneficiary(ies)	%	Contingent Beneficiary(ies)	%

BENEFICIARY DESIGNATION - Other Insured Coverage

Unless otherwise noted in the Additional Information section, the beneficiary of other persons proposed for coverage will be the Primary Insured.

Life Insurance Application (page 2 of 8)

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POLICY/CERTIFICATE INFORMATION

Product Name

Amount of Insurance $

Initial Premium $

❍ Nontobacco
❍ Tobacco

TERM: ❍ Level ❍ Decreasing

Term Period (Number of Years)

Premium Guarantee Period

UNIVERSAL LIFE: ❍ Level ❍ Increasing

Planned Premium $

Initial Allocation Percentage (for equity-indexed UL products only)

Equity Indexed Interest Option _______% Fixed Interest Option _______%

Mode of Payment (For bank draft, complete Bank Draft Plan authorization, and initial payment required.)

❍ Annual ❍ Quarterly ❍ Bi-Weekly Bank Draft
❍ Semi-Annual ❍ Monthly Bank Draft ❍ Other ____________________

Payment in Exchange for Conditional Receipt $

Credit Card (See Instructions Page for current company practice)

❍ Visa ❍ Mastercard

Account Number

Expiration Date

Signature to Authorize Credit Card Charge

(No coverage will be effective except in accordance with the terms of the Receipt and unless full initial modal premium payment is submitted.)

ADDITIONAL BENEFITS - Primary Insured

(Not all riders are available with all products or in all states)

❍ Accelerated Benefit Rider

❍ Accidental Death Benefit Rider Amount: $ ____________________

❍ Critical Illness Rider Amount: $ ____________________ *Supplemental questionnaire required.*

❍ Disability Income Rider

Class: ____________________

Monthly Payout: $ ____________________

❍ 3 month elimination, 2 year benefit

❍ 6 month elimination, 5 year benefit

❍ Return of Premium Rider

❍ Ultimate Income Option Rider *Illustration required.*

Initial Lump Sum: $ ____________________

Monthly Income of: $ ____________________ for ____________ years.

Final Lump Sum: $____________________

❍ Waiver of Monthly Deduction Rider (UL only)

❍ Waiver of Premium Rider (Term only)

❍ Child Rider Amount: $ ____________________ *Supplemental questionnaire required.*

❍ Other: ____

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OTHER INSURED BENEFITS

(Not all riders are available with all products or in all states)

❍ Other Insured/Dependent Rider

Amount: $ ____________________

Term Period: ____________________ yrs.

For term products, term period must match base policy term period.

❍ Disability Income Rider

Class: ____________________

Monthly Payout: $ ____________________

❍ 3 month elimination, 2 year benefit

❍ 6 month elimination, 5 year benefit

❍ Other: ____________________

EXISTING INSURANCE

List existing, personal and business life insurance, disability income, annuity, and long term care coverage. Write NONE if there is no coverage.

Insurance Company	Policy Type	Policy #	Life Insurance or Disability Income Amount	ADB Amount	Year Issued

	Primary Insured	Other Insured
1. Will this policy/certificate, if issued, replace, or change any existing life insurance or annuity? If "Yes", circle which policy/certificate(s) listed above are to be replaced or changed. Amount being replaced $____________________	❍ Y ❍ N	❍ Y ❍ N
2. Is any other insurance application pending? (If yes, provide details): ____________________	❍ Y ❍ N	❍ Y ❍ N
3. Have you had any insurance application declined, postponed, rated, modified, or refused for reinstatement? (If yes, provide details): ____________________	❍ Y ❍ N	❍ Y ❍ N

Life Insurance Application (page 4 of 8)

ADMIN 4952

PERSONAL HISTORY QUESTIONS

	Primary Insured	Other Insured
1. Are you a citizen of the United States? If "No", what is your citizenship? Immigration status? Type of visa?	❍ Y ❍ N	❍ Y ❍ N
2. Have you traveled or resided outside the United States or Canada within the past 2 years or plan to do so within the next 2 years?	❍ Y ❍ N	❍ Y ❍ N
3. Have you been convicted of a felony or are currently on parole for any offense?	❍ Y ❍ N	❍ Y ❍ N
4. In the past 10 years have you been convicted of DWI/DUI? In the past 5 years have you had any speeding tickets or other driving violations?	❍ Y ❍ N	❍ Y ❍ N
5. In the past 5 years have you participated in ballooning, bungee jumping, cliff diving, hang gliding, motorized racing, parachuting, mountain or rock climbing, skin or scuba diving, or any similar avocation?	❍ Y ❍ N	❍ Y ❍ N
6. In the past 5 years have you flown as a pilot, student pilot, or crew member of an aircraft?	❍ Y ❍ N	❍ Y ❍ N
7. In the past 10 years have you ever sought or received treatment, advice, or counseling for the use of alcohol?	❍ Y ❍ N	❍ Y ❍ N
8. Have you ever sought or received treatment, advice, or counseling for the use of any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, or prescription drugs? Have you ever been arrested for the use or possession of such drug or are you currently using these drugs?	❍ Y ❍ N	❍ Y ❍ N
9. Within the past 10 years have you made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury?	❍ Y ❍ N	❍ Y ❍ N
10. Within the past 7 years, have you filed for bankruptcy?	❍ Y ❍ N	❍ Y ❍ N
11. *(Only required when applying for HomeCertain term insurance)* In the past 13 months have you contracted for a home mortgage, or refinanced an existing mortgage? If the answer is yes, please list the amount of the mortgage or refinancing, and the name and address of the lending institution.	❍ Y ❍ N	❍ Y ❍ N

Detail all Yes answers below (additional information may be required).
In addition, complete questionnaires for YES answers to Questions 2, 5, and 6.

Primary Insured

Other Insured

Life Insurance Application (page 5 of 8)

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PERSONAL PHYSICIAN INFORMATION – Primary Insured

(Provide full name, address, and phone number of personal physician. Please write "NONE" if primary insured does not have a personal physician.)

Name

Date Last Seen

Address

Phone

Reason for Last Visit

Result of Last Visit

PERSONAL PHYSICIAN INFORMATION – Other Insured

(Provide full name, address, and phone number of personal physician. Please write "NONE" if primary insured does not have a personal physician.)

Name

Date Last Seen

Address

Phone

Reason for Last Visit

Result of Last Visit

Life Insurance Application (page 6 of 8)

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MEDICAL HISTORY QUESTIONS

	Primary Insured	Other Insured
1. Have you ever been treated for or diagnosed with:		
a) Any heart disease, heart attack, chest pain, high blood pressure, high cholesterol, murmur, palpitations, or any other disorder of the heart or blood vessels?	❍ Y ❍ N	❍ Y ❍ N
b) Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries?	❍ Y ❍ N	❍ Y ❍ N
c) Any breathing or lung disorders, COPD, asthma, bronchitis, sleep apnea, or emphysema?	❍ Y ❍ N	❍ Y ❍ N
d) Diabetes, disorder of the immune system, blood disorder, or disorder of the glands?	❍ Y ❍ N	❍ Y ❍ N
e) Cancer, tumor, or cyst?	❍ Y ❍ N	❍ Y ❍ N
f) Depression, anxiety, dementia, Alzheimer's, or any other mental or nervous disease or disorder?	❍ Y ❍ N	❍ Y ❍ N
g) Hepatitis, gastritis, colitis, or any disease or disorder of the liver, stomach, pancreas, or intestines?	❍ Y ❍ N	❍ Y ❍ N
h) Any disease or disorder of the kidneys, bladder, prostate, urinary, or reproductive systems?	❍ Y ❍ N	❍ Y ❍ N
i) Arthritis or any disease or disorder of the muscles (to include strains or sprains), tendons, bones, spine, back, or joints?	❍ Y ❍ N	❍ Y ❍ N
j) Any disease or disorder of the skin, eyes, or ears?	❍ Y ❍ N	❍ Y ❍ N
k) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive test results indicating the presence of the AIDS virus?	❍ Y ❍ N	❍ Y ❍ N
2. Are you currently prescribed any medication?	❍ Y ❍ N	❍ Y ❍ N
3. Have you been prescribed medication in the past 5 years not previously mentioned?	❍ Y ❍ N	❍ Y ❍ N
4. In the past 10 years, have you:		
a) Been hospitalized or had surgery?	❍ Y ❍ N	❍ Y ❍ N
b) Had any electrocardiograms, x-rays, laboratory tests, treatments, or procedures?	❍ Y ❍ N	❍ Y ❍ N
c) Been recommended to have any test, treatment, or surgery which has not been performed?	❍ Y ❍ N	❍ Y ❍ N
d) Had any illness, disease, or injury that is not included in other answers?	❍ Y ❍ N	❍ Y ❍ N
5. Has any parent, brother, or sister died from or had any occurrence of cancer, heart disease, diabetes, or any hereditary disease prior to age 60?	❍ Y ❍ N	❍ Y ❍ N
6. Have you smoked cigarettes, pipes, or cigars, used snuff, chewed tobacco, or used any nicotine based product such as patch or gum? If yes, please detail the type(s) of tobacco product used and date of last use below.	❍ Y ❍ N	❍ Y ❍ N

Detail all Yes answers (Include name of treating physician, diagnosis, date of diagnosis, and location of medical records)

Primary Insured

Other Insured

Life Insurance Application (page 7 of 8)

ADMIN 4952

AUTHORIZATION

I have read the questions and answers on this application. The statements made in this application are: complete; true; and correctly recorded. **I agree that: a copy of this application will form a part of any certificate/policy issued; and that no agent can pass on insurability or modify any certificate issued by the Insurer. I also agree that, except as provided in this application's Receipt, if issued, no insurance will take effect unless and until both of the following conditions are satisfied during each proposed insured's lifetime and while each proposed insured's health is as stated in this application: (1) this certificate/policy is delivered to and accepted by the Owner; and (2) the full initial premium for the mode of payment chosen is paid at our Home Office.** I acknowledge that I have received, read and understand the notices required by: the Medical Information Bureau, Inc.; and the Federal Fair Credit Reporting Act regarding investigative consumer reports.

I authorize any licensed physician, medical practitioner, hospital, clinic, the Veterans Administration, laboratory or other medical or medically-related facility, the Medical Information Bureau, Inc., insurance companies, a consumer reporting agency, prescription records, Pharmacy Benefit Manager, and my employer to give to the Insurer, its reinsurers, or other designee, medical and other information which may be pertinent to the evaluation regarding me or any member of my family who is applying for life insurance.

I also authorize the Insurer to obtain an investigative consumer report on me or on any member of my family who is also applying for life insurance. I understand that I am entitled to be interviewed by any consumer reporting agency which may be requested to prepare such a report as long as I can reasonably be contacted during normal business hours. Check if interview requested: ❍

I understand that if my coverage includes the Accelerated Benefit Rider and I am later diagnosed with a terminal illness as defined in the rider, I may receive up to 50% of the certificate or policy's death benefit. Since I would receive a portion of my benefits early, the amount payable at the time of my death will be reduced. There is no premium charged for this rider. I understand that receipt of benefits may be taxable, and that the Insurer recommends consultation of a tax advisor prior to exercising this benefit.

I further understand that if I am purchasing a HomeCertain term life product, the mortgage information I supplied will be relied upon to determine my insurability for that product, in conjunction with my health information. As such, inaccurate information about my mortgage may result in a denial, rating, or rescission of my insurance coverage.

I authorize the Insurer and/or its reinsurer(s) to release information in my file to other insurance companies to which I may apply for life or health insurance coverage or to which a claim may be submitted.

This Authorization will be valid from the date signed for a period of 30 months; a photographic copy of this Authorization will be as valid as the original; I, or any of our representatives are entitled to receive a copy of this Authorization.

I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits.

Certification: Under the penalties of perjury, I certify that my Social Security or Tax Identification Numbers provided on this form are true, correct and complete.

Signed at (City and State) on (Date)

Signature of Primary Insured age 15 or more

Signature(s) of Additional Insured(s) age 15 or more

Signature of Owner(s) (if not the Primary Insured or if Primary Insured is less than age 18)

AGENT CERTIFICATION

1) I have asked the questions contained in this application of the Insured(s) and Owner and duly recorded the answers; 2) to the best of my knowledge there is nothing affecting the insurability of any persons proposed for insurance as stated in this application; 3) if the initial premium was paid with the application, I have remitted it to the Insurer and delivered a Conditional Receipt to the Owner; 4) if Disclosure Statements are required by the state, I have given them to the applicant; 5) I have witnessed the signatures on this application.

To the best of my knowledge, this application ❍ does replace ❍ does not replace existing life insurance or annuities.

If so, will this replacement be considered a 1035 Exchange? ❍ Yes ❍ No

Signature of Agent	Date

Print Agent's Name	Agent Number

Agent's Phone Number	Agent's Fax Number	Agent's Email Address

If Bank Representative:	Name of Financial Institution	Branch #	Employee #

Life Insurance Application (page 8 of 8)

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Complete and sign this page if additional space is needed or if the primary insured or owner lives in a state where one of the fraud warnings applies.

ADDITIONAL INFORMATION

If additional space is needed to expand on any section, please use the space below.

Section	Question	Primary Insured	Other Insured	Detail
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	
		❍	❍	

FRAUD WARNING NOTICES

(Please review the notice that applies in your state)

AR/LA: 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.

CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.

DC: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KY/OH: I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud. ____________ *(Owner's Initials)*.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.

NJ: Any person who includes any false or misleading information on an application for an insurance policy/certificate is subject to criminal and civil penalties.

OK: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NM/PA: 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.

TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed at (City and State) on (Date)

Signature of Primary Insured age 15 or more

Signature(s) of Additional Insured(s) age 15 or more

Signature of Owner(s) (if not the Primary Insured or if Primary Insured is less than age 18)

Life Insurance Application

Leave this page with applicant if cash is paid with application.

LIFE INSURANCE CONDITIONAL RECEIPT

PLEASE READ THIS CAREFULLY. **All premium checks must be made payable to:**
OM Financial Life Insurance Company (hereinafter "Insurer").
Do not make check payable to agent/producer or leave payee blank.

Received from ________________________ a check in the amount of $_______________ paid with a life insurance Application to the Insurer. The Application bears the same date as this Receipt. I have advised each proposed insured of the terms, conditions, and limitations of this Conditional Receipt. No agent or broker is authorized to alter the terms of this Receipt, waive any terms or conditions, or pass on insurability.

No agent or broker is authorized to alter the terms of this Receipt, waive any requirements, or pass on insurability.

Dated at (City & State)	On (Date)	Agent's Signature

The life insurance contract you have applied for will not provide insurance coverage unless and until a contract is delivered to you. However, subject to the terms, conditions, and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy/certificate applied for will become effective prior to policy/certificate delivery under the following conditions.

This Receipt will provide life insurance starting at the Effective Date. The Effective Date is the latest date of the following events:

- Signing of all parts of the Application, including any supplement, addenda, or amendment to the Application, and completion of any medical examination portion of the Application;
- Date requested in the Application that is agreed to by the Insurer;
- The full initial premium for the mode of payment chosen is received at our Home Office; or
- Any additional information required by us, including attending physician statement/report, is received at our Home Office.

This Receipt will provide no life insurance unless and until each of the following Requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- As of the Effective Date hereinabove defined, each person proposed to be insured is found to be insurable exactly as applied for in the Application submitted to the Insurer and in accordance with the Insurer's underwriting rules and standards, without any modification as to life insurance product, amount of life insurance coverage, or premium rate;
- The payment taken with the Application is not less than the full initial premium for the mode of payment chosen in the Application and is honored immediately upon presentment;
- All medical examinations, tests, and other screenings required by the Insurer are completed, with results received at the Insurer's Home Office within 60 days from the date of the completion of the Application; and
- As of the Effective Date, the health and all factors affecting the insurability of each person proposed to be insured are as stated in the Application.

If all Requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Insurer shall be limited to a full refund to the Applicant of the premium payment received by the Insurer.

This Receipt will terminate on the earliest date of:

- 60 days from the date this Receipt was executed;
- The date the Insurer mails notice to the Applicant of the rejection of the Application for insurance;
- The day before the date insurance goes into effect under the policy/certificate applied for; or
- The date the Insurer offers insurance other than as applied for.

The aggregate amount of life insurance provided on the life of any person proposed to be insured which may become effective under this Receipt and any other Conditional Receipt issued by the Insurer on the life of that person, shall be the lesser of the amount applied for or $500,000.

This Receipt provides no insurance for riders or additional benefits.

Life Insurance Application

Leave this page with applicant.

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION to Primary Insured And Other Persons Proposed to be Insured, If Any

We may ask for an investigative consumer report in connection with your application. In addition, a report may be requested to update our records if you apply for more coverage. You may ask to be interviewed when such a report is being prepared. We will, upon your written request, let you know whether a report was requested and, if so, give you the name, address and telephone number of the agency making the report. By contacting that agency and giving proper identification, you may inspect or obtain a copy of the report.

Typically, the report will contain information as to character, general reputation, personal characteristics, health, job and finances. When applicable, it will contain information on your: past and present employment record (including job duties); driving record; health history; use of alcohol or drugs; sport, hobby or aviation activities; and marital status. The agency may get information by talking to you or members of your family, business associates, financial sources, neighbors and others you know.

MEDICAL INFORMATION BUREAU, INC., (MIB) PRE-NOTIFICATION to Primary Insured And Other Persons Proposed to be Insured, If Any

Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report thereon to MIB, a not-for-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, the 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. Please contact MIB at (866) 346-3642. 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: Post Office Box 105; Essex Station; Boston, Massachusetts 02112; telephone number (617) 426-3660.

Life Insurance Application

BANK DRAFT PLAN

Please attach a voided check here in addition to your initial premium.

BANK DRAFT PLAN: EFT PREMIUM AUTHORIZATION TO MY BANK

I authorize the payment of debits drawn on my account payable to the insurer, provided there are sufficient funds in said account. I agree that if any such debit be dishonored, the insurer has the right to debit my account the following month for the dishonored debit as well as the scheduled debit for that month. I further agree that if any debit be dishonored, you shall be under no liability in the event the dishonored debit results in the forfeiture of insurance. This authority shall remain in effect until revoked by me in writing and until you actually receive such notice of revocation.

Signature (as it appears on bank records)	Date

HIV Consent Form

INSURER

OM Financial Life Insurance Company

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULT

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician for Reporting a Possible Positive Test Result: ____________________

Address: ____________________

____

HIV Consent Form

INSURER

OM Financial Life Insurance Company

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

CONSENT

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

______________________________ ______________________________
Signature of Proposed Insured or Parent / Guardian Date Signed

______________________________ Address: ______________________________
Name of Proposed Insured ______________________________

HIPAA Authorization for Release of Medical Information

INSURER
❍ OM Financial Life Insurance Company

Name of Proposed Insured (please print or type) ____________________ Date of Birth ____________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, 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, medications prescribed and any other protected health information concerning me to OM Financial Life. 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 records without restriction.

This protected health information is to be disclosed under this Authorization so that OM Financial Life 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 OM Financial Life.

This authorization shall remain in force for 36 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 notification to the entity identified above, 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 OM Financial Life 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by OM Financial Life except as authorized by me or as required by law.

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 records, OM Financial Life 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 will receive a copy of this authorization upon request.

Release all medical records to MID-AMERICA AGENCY SERVICES, INC. (MAAS), 1205 7TH STREET, HARLAN, IOWA 51537 (712-755-2700) authorized representative for OM Financial Life.

Signature of Proposed Insured or Personal Representative ____________________ **Date** ____________

Description of Personal Representative's Authority or Relationship to Patient ____________________

Bank Account Verification Form (Checking or Savings)

INSURER
OM Financial Life Insurance Company

FINANCIAL INSTITUTION			
Name of Financial Institution	Contact Person	Title	Phone No.
Address	City	State	Zip
Type of Account ❍ Checking ❍ Savings	Routing Number	Account Number	
Policy Number	Insured	Policy Owner	Draft Date

Payor's Name: ______________________________________ *(Please Print)*
has a current checking/savings account with the above named financial institution and they will permit checking/savings account drafts. I do hereby attest that I personally verified this information and understand that any intentional misrepresentation or falsification on my part will rescind my privilege of using this form and will precipitate immediate termination of my appointment with OM Financial Life Insurance Company.

Accountholder (Print)	Signature	Date
Policy Owner (Print)	Signature	Date
Agent Name (Print)	Signature	Date

Comments: ______________________________________