UNITED LIFE
INSURANCE COMPANY

LegacyAccel Application Submission Form

Policy #_____

Submission Date _____

Producer Name _____

Producer Code No._____

Applicant Name _____

Producer Contact Information_____

Product Name & Commission Option *(Check One)*

☐ LegacyAccel Standard Commission / Trails Option C

☐ LegacyAccel Commission / Trails Option B

☐ LegacyAccel Up-Front Commission / No Trails Option A

Submitting New Business in Good Order:

Moving your business through the new business process quickly and efficiently is our goal. Submitting fully completed application and supporting documents will assist in the process.

If this form is not received or is incomplete, then the commission will be set at STANDARD COMMISSION/TRAILS Option C.

Completed application, forms and funding can be sent by:

Fax to:
888-726-9736

Email to:
Life@unitedlife.com

Mail to:
United Life Insurance Company
PO BOX 729
Cedar Rapids, IA 52406-0729

Overnight to:
United Life Insurance Company
200 1st St SE, Suite 1300
Cedar Rapids, IA 52401

UNITED LIFE
INSURANCE COMPANY
PO Box 729 • Cedar Rapids, IA 52406
Phone: 800-637-6318 • FAX 888-726-9736

LegacyAccel
APPLICATION FOR INDIVIDUAL LIFE INSURANCE

PROPOSED INSURED

LAST NAME | SUFFIX | FIRST NAME | MIDDLE NAME

STREET ADDRESS | CITY | STATE | ZIP

ARE YOU A U.S. CITIZEN? ☐ **YES** ☐ **NO**

IF NO, ARE YOU A LEGAL PERMANENT U.S. RESIDENT? ☐ **YES** ☐ **NO** If NO, coverage is not available.

TAX ID/SOCIAL SECURITY NUMBER | DRIVERS LICENSE NUMBER | STATE | EXPIRATION DATE or ☐ NO DRIVERS LICENSE

GREENCARD / VISA | EXPIRATION DATE ☐ MALE ☐ FEMALE

DOB (mm/dd/yyyy) | AGE | COUNTRY OF BIRTH | STATE OF BIRTH

OCCUPATION | EMPLOYER

CONTACT PHONE | EMAIL ADDRESS

OWNER (*If different than Proposed Insured*) ☐ **INDIVIDUAL** ☐ **TRUST** ☐ **OTHER** _____

NAME | RELATIONSHIP TO PROPOSED INSURED

STREET ADDRESS | CITY | STATE | ZIP

ARE YOU A U.S. CITIZEN? ☐ **YES** ☐ **NO**

IF NO, ARE YOU A LEGAL PERMANENT U.S. RESIDENT? ☐ YES ☐ NO *If NO, coverage is not available.*

TAX ID/SOCIAL SECURITY NUMBER | Or GREEN CARD VISA NUMBER | EXPIRATION DATE

DOB (mm/dd/yyyy) | CONTACT PHONE | EMAIL ADDRESS

☐ JOINT OWNER *(if applicable)* or ☐ CONTINGENT OWNER *(if applicable)*

LAST NAME | FIRST NAME | MIDDLE NAME U.S. CITIZEN? ☐ **YES** ☐ **NO**

STREET ADDRESS | CITY | STATE | ZIP

DOB (mm/dd/yyyy) | TAX ID/SOCIAL SECURITY NUMBER | CONTACT PHONE | EMAIL ADDRESS

PLAN: INDEXED UNIVERSAL

Please select only one option:

SPECIFIED AMOUNT $ _____

DEATH BENEFIT ☐ Option 1 (Level) ☐ Option 2 (Increasing)

☐ PREFERRED – NON-NICOTINE $100,000+
☐ PREFERRED – NICOTINE $100,000+
☐ STANDARD – NON-NICOTINE
☐ STANDARD – NICOTINE

PAYOR INFORMATION *(If Different than the Insured)*

_____ U.S. CITIZEN? ☐ **YES** ☐ **NO**
PAYOR NAME (Last, First, M)

_____ _____ _____ _____
BILLING ADDRESS CITY STATE ZIP

_____ _____
EMAIL ADDRESS TAX ID/SOCIAL SECURITY NUMBER

_____
SECONDARY PAYOR NAME/ADDRESS FOR PAST DUE PREMIUM NOTICES – Name (Last, First, MI) Address, City, State, Zip

ANNUAL PREMIUM/BILLING: $_____

MODAL PREMIUM AMOUNT: $ _____

SINGLE PREMIUM/LUMP SUM PAYMENT: $ _____

Premium Payment Method/Frequency
☐ Bank Withdrawal/EFT ☐ Mail Billing Notice
(Bank Withdrawal/EFT-Only Available Monthly/Quarterly)

FUNDED VIA 1035 EXCHANGE: $ _____ ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annually
List Bill/EFT AA #_____

INITIAL EXTRA AMOUNT: $ _____ ☐ Wire Transfer ☐ Cash with App/ Check #_____

ALLOCATION OF FUNDS

Whole percentages are required. Total must equal 100%

Select	Account	Percentage
☐	Fixed Account	%
☐	Point-to-Point Cap Indexed Account – S&P 500® Price Return (PR) Index	%
☐	Point-to-Point Participation Indexed Account - S&P® MARC 5% Excess Return Index	%
☐		
	Total	100%

The S&P 500® Price Return Index and S&P® MARC 5% Excess Return Index are products of S&P Dow Jones Indices, LLC, a division of S&P Global, or its affiliates ("SPDJI") and has been licensed for use by United Life Insurance Company. Standard & Poor's® and S&P® are registered trademarks of Standard & Poor's Financial Services LLC, a division of S&P Global ("S&P"); Dow Jones® is a registered trademark of Dow Jones Trademark Holdings LLC ("Dow Jones"). United Life Insurance Company's insurance products are not sponsored, endorsed, sold or promoted by SPDJI, Dow Jones, S&P, or their respective affiliates, and none of such parties make any representation regarding the advisability of investing in such product(s) nor do they have any liability for any errors, omissions, or interruptions of the S&P 500® Price Return Index or S&P® MARC 5% Excess Return Index.

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.

1. In the past 12 months, have you been advised by a member of the medical profession to have any surgery, hospitalization, treatment or test that was not completed or for which you are waiting the results, excluding those tests relating to HIV?

   ☐ YES ☐ NO

2. During the past 5 years, due to a physical or mental impairment, do you require, or have you been advised by a member of the medical profession to receive human assistance with any of the following activities of daily living: eating, dressing, toileting, transferring, bathing, or taking medication?

   ☐ YES ☐ NO

3. Have you ever been diagnosed by a member of the medical profession with Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?

   ☐ YES ☐ NO

4. Have you ever been diagnosed, treated for or prescribed medication by a member of the medical profession for Alzheimer's disease or any other type of dementia?

   ☐ YES ☐ NO

5. Have you had or been advised by a member of the medical profession to have an organ transplant, or have you been medically diagnosed as having a terminal illness or life expectancy of 12 months or less?

   ☐ YES ☐ NO

6. Do you currently use oxygen equipment to assist in breathing, are you currently receiving kidney dialysis, or do you have a defibrillator implanted?

   ☐ YES ☐ NO

7. Within the past 5 years have you been confined to a hospital, nursing facility, convalescent care facility, assisted living facility or mental care facility for more than 7 days?

   ☐ YES ☐ NO

8. Within the past 10 years have you been convicted of a felony, do you have a felony charge currently pending against you or are you currently on probation or parole?

   ☐ YES ☐ NO

9. Within the past 5 years, have you been convicted of more than one violation for operating a vehicle while intoxicated, impaired or under the influence and/or for reckless driving?

   ☐ YES ☐ NO

10. Within the past 2 years have you been declined for life, disability or long-term care insurance?

    ☐ YES ☐ NO

11. If female, are you currently pregnant with gestational diabetes, preeclampsia, toxemia, HELLP syndrome, pregnancy induced hypertension, multiple gestation or have you been diagnosed by a member of the medical profession as high risk?

    ☐ YES ☐ NO ☐ NOT APPLICABLE

12. _____ CURRENT HEIGHT _____ CURRENT WEIGHT

*Within the past **five years**, have you been **diagnosed** with, **treated** for, **prescribed** medication for or been given medical advice by a member of the medical profession for any of the following?*

13. **Any of the following Cardiovascular/Cerebrovascular Conditions or Procedures:**

Angina (chest pain), cardiomyopathy, congestive heart failure, coronary artery disease, heart attack, heart valve disease, peripheral arterial or vascular disease, stroke, or ventricular tachycardia; heart surgery including bypass, angioplasty, stent. ☐ YES ☐ NO

14. **Any of the following Respiratory Conditions:**

Chronic bronchitis, chronic obstructive pulmonary disease (COPD), cystic fibrosis, emphysema, or pulmonary fibrosis. ☐ YES ☐ NO

15. **Any of the following Gastrointestinal/Genitourinary Conditions:**

Chronic hepatitis, chronic kidney disease, chronic pancreatitis, chronic renal failure, cirrhosis, liver disease, sclerosing cholangitis, polycystic kidney disease, or Crohn's disease. ☐ YES ☐ NO

16. **Any of the following Cancers/Carcinomas:**

Bone cancer, brain cancer, cervical cancer, kidney cancer, liver cancer, lung cancer, leukemia, lymphoma, multiple myeloma, ovarian cancer, pancreatic cancer, testicular cancer, or uterine cancer. ☐ YES ☐ NO

17. **Any of the following Psychiatric/Dependency Conditions:**

Alcohol dependency or abuse, drug dependency or abuse, schizophrenia, or suicide attempt. ☐ YES ☐ NO

18. **Any of the following Neurological/Musculoskeletal Conditions:**

ALS (Lou Gehrig's disease), Huntington's disease, muscular dystrophy, or paralysis. ☐ YES ☐ NO

19. **Any of the following Immune System/Blood Conditions:**

Chronic anemia (other than iron deficiency anemia), CREST syndrome or scleroderma, or systemic lupus. ☐ YES ☐ NO

20. **Any of the following:**

Down syndrome or autism. ☐ YES ☐ NO

21. Have you used tobacco or nicotine delivery products (excluding smoking of up to 48 cigars) in the past 24 months? ☐ YES ☐ NO

21a. Do you currently use or have you used tobacco or nicotine delivery products (excluding smoking of up to 24 cigars) in the past 12 months? ☐ YES ☐ NO

22. Do you currently use or have you used marijuana or marijuana products in the past 12 months? ☐ YES ☐ NO

22a. Do you use marijuana or marijuana products more than 12 times per month? ☐ YES ☐ NO

22b. Do you use marijuana or marijuana products prescribed by a physician for a medical condition more than 12 times per month? ☐ YES ☐ NO

*Within the past **five years**, have you been **diagnosed** with, **treated** for, **prescribed** medication for or been given medical advice by a member of the medical profession for any of the following?*

23. **Diabetes or Pre-diabetes** (If NO, skip to question 24) ☐ YES ☐ NO

23a. Have you used insulin within the past 12 months? ☐ YES ☐ NO

23a1. Were you diagnosed before age 20? ☐ YES ☐ NO

23a2. Did you begin taking insulin before age 40? ☐ YES ☐ NO

23b. Have you been hospitalized two or more times for any complications within the past 2 years? ☐ YES ☐ NO

23c. Within the past 12 months have you had a hemoglobin A1c result greater than 8.5? ☐ YES ☐ NO

23d. Was there a change to your diabetes medications or an increase in the dosage at your last physician visit? ☐ YES ☐ NO

23e. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

24. **Atrial fibrillation** (If NO, skip to question 25) ☐ YES ☐ NO

24a. Have you experienced an abnormal heart rhythm in the past 12 months? ☐ YES ☐ NO

24b. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

25. **Transient Ischemic Attack (TIA)** (If NO, skip to question 26) ☐ YES ☐ NO

25a. Have you experienced 3 or more TIAs in the past 3 years? ☐ YES ☐ NO

25b. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

26. **Aneurysm** (If NO, skip to question 27) ☐ YES ☐ NO

26a. Surgically repaired? ☐ YES ☐ NO

26b. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

27. **Carotid artery disease** (If NO, skip to question 28) ☐ YES ☐ NO

27a. Diagnosed within the past 6 months? ☐ YES ☐ NO

27b. Treated with surgery? ☐ YES ☐ NO

27c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

28. **Blood clot/phlebitis/thrombophlebitis** (If NO, skip to question 29) ☐ YES ☐ NO

28a. 3 or more episodes or clots identified? ☐ YES ☐ NO

28b. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

29. **Seizures** (If NO, skip to question 30) ☐ YES ☐ NO

29a. Diagnosed within the past 6 months? ☐ YES ☐ NO

29b. Do you experience 7 or more seizures per year? ☐ YES ☐ NO

29c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

30. **Asthma** (If NO, skip to question 31) ☐ YES ☐ NO

30a. Have asthma symptoms caused you an emergency room visit or hospitalization in the past 12 months? ☐ YES ☐ NO

30b. Do you average 13 or more asthma attacks per year? ☐ YES ☐ NO

30c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

31. **Depression** (If NO, skip to question 32) ☐ YES ☐ NO

31a. Have you been hospitalized for depression in the past 5 years? ☐ YES ☐ NO

31b. Have you had electroconvulsive treatment (ECT) in the past 5 years? ☐ YES ☐ NO

31c. Have you had suicidal ideas or thoughts in the past 2 years? ☐ YES ☐ NO

31d. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

32. **Bipolar disorder** (If NO, skip to question 33) ☐ YES ☐ NO

32a. Have you been hospitalized due to your bipolar disorder in the past 5 years? ☐ YES ☐ NO

32b. Have you had suicidal ideas or thoughts in the past 2 years? ☐ YES ☐ NO

32c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

33. **Anxiety** (If NO, skip to question 34) ☐ YES ☐ NO

33a. Have you been hospitalized due to your anxiety in the past 5 years? ☐ YES ☐ NO

33b. Have you had suicidal ideas or thoughts in the past 2 years? ☐ YES ☐ NO

33c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

34. **Post-Traumatic Stress Disorder (PTSD)** (If NO, skip to question 35) ☐ YES ☐ NO

34a. Have you been hospitalized due to your post-traumatic stress disorder in the past 5 years? ☐ YES ☐ NO

34b. Have you had suicidal ideas or thoughts in the past 2 years? ☐ YES ☐ NO

34c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

35. **Parkinson's disease** (If NO, skip to question 36) ☐ YES ☐ NO

35a. Age at diagnosis? _____

35b. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

36. **Multiple sclerosis** (If NO, skip to question 37) ☐ YES ☐ NO

36a. Have you had 3 or more attacks in the past 12 months? ☐ YES ☐ NO

36b. Age at diagnosis? _____

36c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

37. **Rheumatoid arthritis** (If NO, skip to question 38) ☐ YES ☐ NO

37a. Do you use a walker or other walking aid? ☐ YES ☐ NO

37b. Have you been diagnosed with rheumatoid nodules in heart, lung or brain? ☐ YES ☐ NO

37c. Are you currently taking the prescription drug Prednisone? ☐ YES ☐ NO

c1. Please indicate the current daily dosage taken.

- ☐ 1 – 10 milligrams
- ☐ 11 – 15 milligrams
- ☐ more than 15 milligrams

37d. Excluding Prednisone, please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

38. **Any of the following cancers?** (If NO, skip to question 39) ☐ YES ☐ NO

38a. bladder ☐ YES ☐ NO

38b. breast ☐ YES ☐ NO

38c. colon ☐ YES ☐ NO

38d. melanoma ☐ YES ☐ NO

38e. prostate ☐ YES ☐ NO

38f. thyroid ☐ YES ☐ NO

38g. Have you been diagnosed or received treatment within the past 12 months? ☐ YES ☐ NO

38h. Was your cancer stage 3 or higher? ☐ YES ☐ NO

38i. Has your cancer been treated by surgery, chemotherapy or radiation? ☐ YES ☐ NO

39. **Obstructive sleep apnea** (If NO, skip to question 40) ☐ YES ☐ NO

39a. Diagnosed within the past 3 months? ☐ YES ☐ NO

39b. Are you compliant with the treatment as prescribed by your doctor? ☐ YES ☐ NO

39c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

40. **Ulcerative colitis** (If NO, skip to question 41) ☐ YES ☐ NO

40a. Diagnosed within the past 12 months? ☐ YES ☐ NO

40b. Have you had surgery for ulcerative colitis in the past 12 months? ☐ YES ☐ NO

40c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

41. **High blood pressure (hypertension)** (If NO, skip to question 42) ☐ YES ☐ NO

41a. Within the past 12 months have you had a blood pressure reading greater than 140/90? ☐ YES ☐ NO

41b. Within the past 12 months have you had a blood pressure reading greater than 160/105? ☐ YES ☐ NO

41c. Has your high blood pressure caused a hospitalization or emergency room visit in the past 12 months? ☐ YES ☐ NO

41d. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

42. **High cholesterol** (If NO, skip to question 43) ☐ YES ☐ NO

42a. Has your total cholesterol been greater than 240 or your cholesterol/HDL ratio been higher than 5.5 in the past 12 months? ☐ YES ☐ NO

42b. Has your total cholesterol been greater than 400 in the past 12 months? ☐ YES ☐ NO

42c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

43. **Chronic pain** (If NO, skip to question 44) ☐ YES ☐ NO

43a. Diagnosed within the past 6 months? ☐ YES ☐ NO

43b. Are you taking more than one opioid pain medication? ☐ YES ☐ NO

43c. Please list names and dosages of any medication currently being taken for this condition.

Prescription Drug	Dosage

44. Other than previously acknowledged, and except for minor, non-recurring illnesses or events, have you taken any prescription medications, had treatments or therapy or been under medical observation by a member of the medical profession, or had an abnormal electrocardiogram, abnormal blood study or other abnormal diagnostic test, except those related to the Human Immunodeficiency Virus (AIDS virus) within the past 12 months?

☐ YES ☐ NO

44a. If yes, provide details below including dates, diagnosis and prescription medications/dosages.

45. Please provide the name of the doctor(s), practitioner(s), or health care facility(ies) that can provide the most complete and up-to-date medical information regarding the health of the proposed insured.

PROVIDER FIRST NAME________________________PROVIDER LAST NAME ________________________

BUSINESS NAME______________________________PHONE NUMBER _____________________________

ADDRESS LINE 1 ____

ADDRESS LINE 2 ____

CITY__________________________________STATE_____________ZIP _______________

PROVIDER FIRST NAME________________________PROVIDER LAST NAME ________________________

BUSINESS NAME______________________________PHONE NUMBER _____________________________

ADDRESS LINE 1 ____

ADDRESS LINE 2 ____

CITY__________________________________STATE_____________ZIP _______________

PROVIDER FIRST NAME________________________PROVIDER LAST NAME ________________________

BUSINESS NAME______________________________PHONE NUMBER _____________________________

ADDRESS LINE 1 ____

ADDRESS LINE 2 ____

CITY__________________________________STATE_____________ZIP _______________

46. What is your annual earned income for the past calendar year? $_____

47. What is your personal net worth?

47a. $0-$250,000 ☐

47b. $250,001-$1,000,000 ☐

47c. $1,000,001 or more ☐

48. Total Amount of existing or pending life insurance coverage with other companies?

$ _____ ☐ None

49. Total amount of existing life insurance coverage with United Life Insurance Company?

$ _____ ☐ None

50. Have you ever flown or intend within the next 2 years to fly, other than as a passenger on a scheduled airline?

☐ YES ☐ NO

51. Are you currently or do you intend within the next 2 years to engage in any of the following activities?

51a. motor sports ☐ YES ☐ NO

51b. rock or mountain climbing ☐ YES ☐ NO

51c. skin or scuba diving ☐ YES ☐ NO

51d. aeronautics (hang gliding, skydiving, parachuting, ultralight flying, soaring, ballooning) ☐ YES ☐ NO

51e. backcountry skiing ☐ YES ☐ NO

52. Has a biological parent or sibling died prior to age 60 due to heart or vascular disease, cancer or diabetes?

☐ YES ☐ NO

53. In the past 5 years have you pled guilty to or been convicted of operating a vehicle while intoxicated, impaired or under the influence; or pled guilty to or been convicted of more than 3 moving violations in the past 3 years?

☐ YES ☐ NO

BENEFICIARY DESIGNATION *(Will be Revocable and Per Stirpes if not indicated.)*

If premium is being paid from a new income annuity, the beneficiaries designated below will be the same beneficiaries for Income Annuity.

PER STIRPES—if a named beneficiary dies before the insured, proceeds will be paid to the surviving direct descendants of that beneficiary.
PER CAPITA—if named beneficiary dies before the insured, proceeds that would have been paid to that beneficiary will be divided equally among the other surviving named beneficiaries of that same class.

If there are more beneficiaries, include the information below on a separate page. It must be signed and dated by the owner(s).

Primary Beneficiary

☐ Revocable or ☐ Irrevocable

☐ Per Stirpes or ☐ Per Capita

Divide Proceeds Equally ☐ Yes ☐ No

1. Name _____ %
   Relationship _____
   SS# _____ Date of Birth _____
   Address _____
   _____
2. Name _____ %
   Relationship _____
   SS# _____ Date of Birth _____
   Address _____
   _____
3. Name _____ %
   Relationship _____
   SS# _____ Date of Birth _____
   Address _____
   _____

Contingent Beneficiary

☐ Revocable or ☐ Irrevocable

☐ Per Stirpes or ☐ Per Capita

Divide Proceeds Equally ☐ Yes ☐ No

1. Name _____ %
   Relationship _____
   SS# _____ Date of Birth _____
   Address _____
   _____
2. Name _____ %
   Relationship _____
   SS# _____ Date of Birth _____
   Address _____
   _____
3. Name _____ %
   Relationship _____
   SS# _____ Date of Birth _____
   Address _____
   _____

ASSIGNMENT Is this policy assigned? ☐ YES ☐ NO

If yes, must attach a completed assignment form in order for assignment to be effective for this policy.

SUITABILITY

1. Is the proposed insured or the owner planning to enter into any arrangement to pay the premiums due under this policy? ☐ YES ☐ NO

   (If yes, explain below)

2. Does the proposed insured or owner intend to sell or transfer any interest in any policy issued as a result of this application? ☐ YES ☐ NO

Explain any "YES" answers. Provide details, dates, etc.

_____

_____

_____

_____

3. Do you have existing life insurance or annuity contracts with this or any other company? ☐ YES ☐ NO
4. Is this insurance intended to replace or change existing life insurance or annuity with this or any other company? ☐ YES ☐ NO

If yes to either question, complete the replacement form as required by state law and submit it with this application.

IRS TAXPAYER CERTIFICATION Under penalties of perjury, I (we) as Policy Owner(s), certify: (1) that the number(s) shown on this application is my correct Social Security or Taxpayer Identification Number (TIN) (or I (we) am waiting for a number to be issued to me), (2) I (we) am not subject to backup withholding under Section 3406 (a)(1)(C) of the Internal Revenue Code; and (3) I (we) am a U.S. person(s) (including a U.S. resident alien).

MEDICAL AUTHORIZATION / PERSONAL INFORMATION I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, pharmacy benefit manager, insurance company, insurance support organization, department of motor vehicles, employer, or the MIB Inc., formerly known as the Medical Information Bureau, Inc., to give United Life Insurance Company, or its reinsurers, all information from the past 10 years that it holds, that pertains to driving records, medical consultations, treatments, prescription records, surgeries, and hospital confinements including, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage. I authorize United Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. The MIB is a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This authorization shall be valid for 24 months or if otherwise, the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, following the date of my signature. I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at PO Box 729, Cedar Rapids, Iowa 52406-0729. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers has relied on this Authorization or to the extent that United 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 may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United 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 acknowledge I have received a copy of this Authorization and I agree that a photocopy of this Authorization shall be as valid as the original.

This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

ACKNOWLEDGEMENT I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties.
The undersigned applicant(s) acknowledges receipt of the Notice to Applicant and Authorization to Release Medical/Personal Information and the Fair Credit Reporting Act Notice.

City and State where signed _____ **Date** _____

X _____
SIGNATURE OF PROPOSED INSURED
(or parent if Proposed Insured is a minor)

X _____ Date _____
SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED

X _____ Date _____
SIGNATURE(S) OF OWNER(S) IF OTHER THAN PROPOSED INSURED

If a Trust, Power of Attorney (POA) or Corporation is the Owner, must submit a copy of the Trust agreement, POA documents or Corporate Resolution.

I, the AGENT, certify that I have used only insurer-approved or provided sales material. I also certify that I have left a copy of all sales material, replacement forms and disclosures with the applicant. I also certify that I have seen a government issued ID to confirm the identity of the insured.

Are there existing life insurance or annuity contracts on the life of the insured? ☐ YES ☐ NO

Is this policy intended to replace existing insurance or annuity with this or any other company? ☐ YES ☐ NO

_____ _____
SIGNATURE OF AGENT AGENT'S PRINTED NAME

_____ _____ _____%
AGENCY NAME SIGNING AGENT'S 10 DIGIT CODE # SPLIT %

_____ _____ _____%
DATE SPLIT AGENT'S NAME, 10 DIGIT CODE # SPLIT %

_____
Agent's FLORIDA License Number if signed in Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

CONDITIONAL RECEIPT

AGENT: VALID ONLY WHEN ONE MONTH'S PREMIUM HAS BEEN COLLECTED

Unless every condition specified in Paragraph "First" below is fulfilled exactly, no insurance will become effective prior to Policy Delivery. No agent of the Company may alter or waive any conditions.

RECEIVED FROM_____ this_____day of_____, 20_____the sum of $_____in connection with this application for life insurance to United Life Insurance Company.

_____	_____	_____
NAME	DATE	AMOUNT

The application bears the same date as this receipt. (Checks must be payable to United Life Insurance Company.)

All premium checks must be made payable to the insurance company. Do not make the check payable to the agent or leave the payee blank.

Type of Policy applied for: Indexed Universal Life

FIRST. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery.

(a) the amount of premium taken with the application must be at least equal to the amount of one full monthly premium for the amount of insurance which may become effective prior to policy delivery; and

(b) all outstanding requirements must be completed within 60 days from the date of the application; and

(c) the Proposed Insureds must be on the Effective Date, as defined below, a risk acceptable to the Company under its rules, limits and standards for the plan and for the amount applied for without modification and at the rate of premium paid; and

(d) with respect to any life and disability insurance applied for, on the effective date, the Proposed Insureds must have no changes in health since the date of application.

Then the insurance as applied for in an amount not exceeding $99,999 will become effective as of the latest of: (a) the date of the application, or (b) the date of completion of all medical examinations, tests, and electrocardiograms required by the Company or (c) the Date of Issue, if any, requested on the application.

SECOND. Limits Provision:
The maximum amount of insurance which may become effective prior to policy delivery shall not exceed a total of $99,999 for this and any other applications pending with this Company.

THIRD. Return of Premiums Paid.
If one or more of the conditions in paragraph "FIRST" have not been fulfilled exactly, there shall be no liability on the part of the Company except to return Premiums paid.

_____
(Signature of Agent)

NOTICES TO APPLICANTS

AGENT: GIVE TO APPLICANT IN EVERY CASE

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

Information regarding the proposed insured(s) insurability will be treated as confidential. United Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of 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 the proposed insured(s), MIB will arrange disclosure of any information it may have on file. Please contact MIB at 866-692-6901. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

United Life Insurance Company or its reinsurers may also release information in their 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. The Company will make such other disclosures as are permitted by law. Information for consumers about MIB may be obtained on its website at: www.mib.com.

UNITED LIFE
INSURANCE COMPANY

NOTICE TO APPLICANT AND AUTHORIZATION TO RELEASE MEDICAL/PERSONAL INFORMATION

This authorization complies with the HIPAA Privacy Rule

X _____ _____

NAME OF PROPOSED INSURED (PRINT OR TYPE) DATE OF BIRTH

NOTICES TO APPLICANTS

AGENT: ***Give to Applicant in every case***

The processing of your application and future insurance transactions may include a routine inquiry by United Life Insurance Company. This inquiry, if made, may provide applicable information concerning character, general reputation, personal characteristics, personally identifiable financial information and mode of living except as may be related directly or indirectly to the proposed insured(s) sexual orientation. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

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MEDICAL/PERSONAL INFORMATION AUTHORIZATION I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, pharmacy benefit manager, insurance company, insurance support organization, department of motor vehicles, employer, or the MIB Inc., formerly known as the Medical Information Bureau, Inc., to give United Life Insurance Company, or its reinsurers, all information from the past 10 years that it holds, that pertains to driving records, medical consultations, treatments, prescription records, surgeries, and hospital confinements including, but not limited to, HIV testing (limited to FDA approved tests; HIV test results received from an alternate test site or a home test kit need not be revealed) and the diagnosis and treatment of communicable disease, ARC, AIDS, chemical dependency or psychiatric illness concerning my physical and mental condition and employment records. This otherwise protected information is to be disclosed so that United may underwrite my application for coverage, obtain reinsurance, and conduct any other legally permissible activities related to my coverage.

I authorize United Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. The MIB is a not-for-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. United Life Insurance Company or its reinsurers may also release information to other life insurance companies to whom I apply for life or health insurance.

This authorization shall be valid for 24 months or if otherwise, the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

I understand I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to United Life at PO Box 729, Cedar Rapids, Iowa 52406. Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of the above providers have relied on this Authorization or to the extent that United 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 may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that if I refuse to authorize release of my complete medical record, United 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 acknowledge that I have received a copy of this Authorization and I agree that a photocopy of this Authorization shall be as valid as the original. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

ACKNOWLEDGMENT I (we) verify that the statements and answers provided are true and complete to the best of my knowledge and belief and are to be considered as the basis for any insurance written as a result of this application. All statements are deemed representations and not warranties. The undersigned applicant(s) acknowledges receipt of the Notice to Applicant and Authorization to Release Medical/Personal Information and the Fair Credit Reporting Act Notice.

X _____ _____

SIGNATURE OF PROPOSED INSURED DATE

UNITED LIFE INSURANCE COMPANY

Single Authorization Agreement for a Preauthorized Premium Withdrawal

Company Name: UNITED LIFE INSURANCE COMPANY

I hereby authorize United Life Insurance Company to initiate a premium withdrawal from my checking account for a one-time payment on the policy(ies) listed below.

Policy Number	Print Name of Insured	Premium Payment	Total

Please indicate: _____ New Business Policy _____ Existing

PLEASE PLACE COPY OF VOIDED CHECK HERE. DO NOT SEND A DEPOSIT SLIP.
DO NOT SEND THE ORIGINAL OF THE CHECK. YOU RUN THE RISK OF HAVING THE MONEY DRAFTED TWICE.

I UNDERSTAND THAT THIS AUTHORITY IS ONLY FOR A SINGLE WITHDRAWAL FROM THE NAMED BANKING INSTITUTION. ANY FUTURE REQUEST FOR A PREMIUM WITHDRAWAL WILL REQUIRE A NEW AUTHORIZATION FORM BE COMPLETED ALONG WITH A COPY OF A VOIDED CHECK.

_____ Date: _____

Signature of premium payor as shown on bank records

Send your request to: **United Life Insurance Company**

PO Box 729, Cedar Rapids, IA 52406-0729

800-637-6318 • FAX 888-726-9736 • UnitedLife.com

UNITED LIFE INSURANCE COMPANY

1035 Exchange/Transfer Form

This form applies only to life and annuity accounts. Use LIU-409 for other types of fund transfers: CDs, mutual funds, etc.

Existing Company			Phone Number (important)
Existing Company Street Address (Required)	City	State	Zip
Existing Contract Number or Numbers	Approximate Amount of Transfer	❑ Transfer funds immediately	
Account Type ❑ Life ❑ Annuity	Name of Fund		
Insured's/Annuitant's Name		Insured's/Annuitant's S.S. No.	
Owner/Owner's Name		Owner's Social Sec. No.	

COMPLETE ONE SECTION ONLY

REQUEST FOR 1035 EXCHANGE LIFE INSURANCE OR NON-QUALIFIED ANNUITY CONTRACT

I hereby absolutely assign all of my right, title and interest in and to the above referenced contract to United Life Insurance Company, including, but not limited to, the right to surrender, assign, transfer or change beneficiary.

Section 1035 of the Internal Revenue Code permits certain nontaxable exchanges of insurance and annuity policies. It is my intention that this transfer qualify as a Section 1035 exchange and that no portion of this exchange be actually or constructively received by me. United Life Insurance Company makes no representation concerning my tax treatment for this transaction and the company has no responsibility nor liability for my tax treatment. I understand the exact amount of the proceeds may vary depending upon the date of transfer, and I agree to execute any additional documents required to complete the transfer. I understand that the exchange is not complete if the company issuing the contract is unable or unwilling to pay the value of the above referenced contract to United Life Insurance Company within six (6) months of the request for surrender or if said company is placed under the control or supervision of a state insurance department. I request that this transfer be accomplished as quickly as possible.

❑ Please liquidate account in full.

❑ Please liquidate $_____ of my account.

❑ Please liquidate on the Maturity Date of _____

❑ Lost Policy. I cannot locate the policy

❑ The account to which the funds are being transferred is a life policy.

❑ The account to which the funds are being transferred is a non-qualified annuity

_____

Owner's Signature Date

_____

Co-Owner's Signature or Spouse* Date

***Spouse signature required in community Property states AZ, ID, LA, NM, TX, WA, WI, CA, NV**

QUALIFIED PLAN TRANSFER REQUEST

AUTHORIZATION TO TRANSFER FUNDS

❑ Please liquidate account in full.

❑ Please liquidate $_____ of my account.

❑ Please liquidate _____% of my account.

❑ Please liquidate:

- ❑ on the Maturity Date of _____
- ❑ upon receipt of this request. I/we are aware of any penalty that may be imposed from an early withdrawal. (initials)

and transfer to the annuity I have established through United Life Insurance Company

❑ Lost Policy. I cannot locate the policy.

The account to which the funds are being transferred is:

❑ IRA ❑ Roth IRA ❑ SEP

❑ Rollover Roth IRA ❑ Inherited IRA

❑ Other_____

_____

Owner's Signature Date

_____

Co-Owner's Signature or Spouse*

NOTE: Age 72 restrictions apply to a transfer from a qualified plan retirement account. If you are age 72 or older this year, you may not trans-fer or rollover required minimum distribution amounts. If necessary, instruct your present trustee/custodian, prior to effecting this request to either: (1) pay your own required minimum distribution to you now; or (2) retain the amount for distribution to you later.

NOTE: A signature guarantee may be required by transferring company.

Signature Guarantee By: Name of Bank or Firm

Signature of Officer & Title

Below: to be completed by United life Insurance Company

Acceptance by United Life Insurance Company

United Life Policy Number: _____

By signing below, United Life Insurance Company agrees to accept the transfer described above for the Plan established on behalf of the above named individual. We request the liquidation and transfer of funds indicated above.

MAILING INSTRUCTIONS: Mail proceeds directly to:

PO Box 729, Cedar Rapids, IA 52406-0729 • 800-637-6318 • FAX 888-726-9736 • UnitedLife.com

Date _____ By _____ Title _____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ YES ☐ NO

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____
Applicant's Signature Date

_____ _____
Applicant's Signature Date

_____
Agent's Name (Printed or Typed)

_____
Agent's Address (Printed or Typed)

_____
Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured

UNITED LIFE INSURANCE COMPANY

PO Box 729, Cedar Rapids, IA 52406-0729
800-637-6318 • Fax 785-368-1383 • www.unitedlife.com

UNITED LIFE
INSURANCE COMPANY
PO Box 729
Cedar Rapids, IA 52406-0729
Phone: 1-800-637-6318

Illustration Certification

This form must be completed at time of application and submitted with the application if an NAIC compliant proposal is required and none accompanies the application at the time it is submitted to the home office.

If you have any questions regarding the use of this form, please be sure to contact your marketing representative or our home office marketing department at the address above.

YOU MUST MARK ONE OF THE BOXES BELOW AS IT APPLIES TO THE ATTACHED APPLICATION AND BE SURE TO HAVE THE OWNER SIGN IN THE APPROPRIATE SPOT. YOU ALSO MUST SIGN AND DATE THE FORM.

OPTION 1

☐ No illustration used.

I certify that I have not illustrated the benefits for which the attached application is being made.

X_____ _____
Agent Date

I certify that I have not seen an illustration for the benefits for which the attached application is being made.

X_____ _____
Owner Date

OPTION 2

☐ Only computer screen display used.

I certify that I displayed a computer screen illustration for _____(Owner) that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

1. Gender..... Male ○ Female ○
2. Age..... _____
3. Underwriting or Rating Class..... _____
4. Type of Policy..... _____
5. Initial Death Benefit.....$ _____
6. Dividend Option..... Not Applicable

X_____ _____
Agent Date

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

X_____ _____
Owner Date