

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

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

**Overnight to:**  
United Life Insurance Company  
200 1<sup>st</sup> St SE, Suite 1300  
Cedar Rapids, IA 52401

**Email to:**  
[Life@unitedlife.com](mailto:Life@unitedlife.com)



**PLAN: INDEXED UNIVERSAL**

Please select only one option:

SPECIFIED AMOUNT \$ \_\_\_\_\_

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

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

**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)

- Monthly  Quarterly  Semi-Annual  Annually

List Bill/EFT AA # \_\_\_\_\_

FUNDED VIA 1035 EXCHANGE: \$ \_\_\_\_\_

- Wire Transfer  Cash with App/ Check # \_\_\_\_\_

INITIAL EXTRA AMOUNT: \$ \_\_\_\_\_

**ALLOCATION OF FUNDS**

Whole percentages are required. Total must equal 100%

Select	Account	Percentage
<input type="checkbox"/>	Fixed Account	%
<input type="checkbox"/>	Point-to-Point Cap Indexed Account – S&P 500® Price Return (PR) Index	%
<input type="checkbox"/>	Point-to-Point Participation Indexed Account - S&P® MARC 5% Excess Return Index	%
<input type="checkbox"/>		
	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. Within the past 12 months, have you been treated for, diagnosed with or tested positive by a member of the medical profession for the novel coronavirus (SARS-CoV-2/COVID-19)? (If NO, skip to question 45)

YES  NO

44a. Have you recovered from the virus and been released from doctor's care?  YES  NO

45. 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

45a. If yes, provide details below including dates, diagnosis and prescription medications/dosages.

--

46. 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 \_\_\_\_\_

47. What is your annual earned income for the past calendar year? \$ \_\_\_\_\_

48. What is your personal net worth?

48a. \$0-\$250,000

48b. \$250,001-\$1,000,000

48c. \$1,000,001 or more

49. Total amount of existing or pending life insurance coverage with other companies?

\$ \_\_\_\_\_  None

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

\$ \_\_\_\_\_  None

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

YES  NO

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

52a. motor sports  YES  NO

52b. rock or mountain climbing  YES  NO

52c. skin or scuba diving  YES  NO

52d. aeronautics (hang gliding, skydiving, parachuting, ultralight flying, soaring, ballooning)  
 YES  NO

52e. backcountry skiing  YES  NO

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

YES  NO

54. Have you traveled or lived outside the United States within the past 2 years or plan to travel or live outside the United States within the next 2 years?

YES  NO

55. 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, 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, 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.



## 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](http://www.mib.com).

**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.

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.

**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

**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.

\_\_\_\_\_  
Signature of premium payor as shown on bank records

Date: \_\_\_\_\_

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](http://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