Companion Life Insurance Company
A Mutual *of* Omaha Company

NEW YORK – Application for Life Insurance

Fully Underwritten Products – One Base Policy Per Application

✍ *Checklist for Submitting a Complete Application*

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

☞ Please use the precise Product and Plan on the application to avoid app amends

❑ **Universal Life Product Names:**
- AccumUL Plus • AccumUL Answers • Guaranteed Universal Life Survivor
- Guaranteed Universal Life • Guaranteed Universal Life Plus

❑ **Universal Life Rider Names:**
- Disability Waiver of Policy Charges Rider
- Disability Continuation of Planned Premium Rider
- Accidental Death Benefit Rider
- Dependent Children's Rider

❑ **AccumUL Plus & AccumUL Answers Only:**
- Additional Insured Rider Self • Additional Insured Rider Spouse
- Additional Insured Rider Other Insured

❑ **Guaranteed Universal Life Survivor Only:**
- Four Year Level Term Insurance Rider
- For 2nd Insured – Place their information in PART 1A PAGE 2 of 2 in section "Rider on Other Proposed Insured"

❑ **Term Product Names:**
- Term Life Answers

❑ **Term Life Rider Names:**
- Waiver of Premium
- Accidental Death Benefit Rider
- Children's Rider
- Other Insured Rider

✎Application Submission Guidelines

❑ Attach a cover letter or additional information as needed, **and** Always submit the Producer Statement and Producer Report page
❑ Always obtain signed HIPAA and MIB authorizations
❑ Always provide client with MIB Inc Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Investigative Consumer Reports Notice, Summary of Rights and Life Insurance Buyer's Guide
❑ All changes should be initialed by the Applicant / Owner
❑ If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client
❑ If selecting the Disability Continuation of Planned Premium Rider, Accidental Death Benefit Rider, Dependent Children's Rider, Additional Insured Rider or the Other Insured Rider, a **RIDER AMOUNT** must be entered on the application.

✎Important Forms

❑ Replacement Forms – Submit a signed Y5415_0415 "Definition of Replacement" form. This form must be completed **even if this is not a replacement (except Companion to Companion contractual conversions using the YA0197-0611 application)**. If replacement is involved, follow the Regulation 60 Replacement Guidelines. Replacement forms can be ordered in a packet or printed through Sales Professional Access
❑ Payment Authorization – Complete this form if applicable
❑ Conditional Receipt Reminders - If money can be collected, the Conditional Receipt must be completed, date and signed by the Producer and the Applicant/Owner
❑ Submit a signed Accelerated Benefit Rider Disclosure Form for TLA, AccumUL Plus, AccumUL Answers, GUL and GUL Plus
❑ Submit a signed HIV consent form, if applicable
❑ Submit a copy of the illustration or the acknowledgement form
❑ If face amount is $1,000,000 and above and the Proposed Insured is age 65 or over you will need: (a) signed Statement of Policyowner form and, (b) signed Premium Funding and Acknowledgement form
❑ Submit a signed copy of the Disability Monthly Premium Benefit Rider Disclosure if applying for the Disability Continuation of Planned Premium Rider
❑ Federal Form F4506T-EZ - Used to request tax records for the insured. This form is required for applications with a face amount of $5 Million or more and may be requested by underwriting as necessary.

✎Supplemental Applications, Forms and Buyer's Guide:

- ***Children's Rider Application:*** Complete if applicable
- ***Juvenile Life Insurance Supplemental Application:*** Complete if Proposed Insured is age 0-17 years
- ***1035 Exchange:*** By exercising a 1035 (a) exchange, the client may transfer the money from the old carrier to United of Omaha without incurring a taxable gain for federal income tax purposes
- ***Buyer's Guide:*** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale

Paramedical Vendors	✎Indicate underwriting requirements initiated or, completed on the Proposed Insured(s)	
APPS – 1-800-635-1677 **EMSI** – 1-800-872-3674 **ExamOne** – 1-877-933-9261 **Portamedic** – 1-800-765-1010 **Superior Mobile Medics** – 1-800-898-3926	**Primary Proposed Insured** ☐ Blood Profile ☐ Physical Data ☐ Urinalysis ☐ Long Form Exam ☐ MD Exam ☐ Treadmill EKG ☐ EKG	**Other Proposed Insured:** ☐ Blood Profile ☐ Physical Data ☐ Urinalysis ☐ Long Form Exam ☐ MD Exam ☐ Treadmill EKG ☐ EKG

Companion Life Insurance Company
A Mutual *of* Omaha Company
888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

PART 1A, PAGE 1 OF 2 LIFE INSURANCE APPLICATION

PROPOSED INSURED

Proposed Insured Legal Name _____

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

Date of Birth _____ State of Birth _____ Annual Income _____

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

Legal Residence Address _____
Street City State ZIP

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

Occupation/Duties _____ Employer _____

If Proposed Insured is age 0-17 complete Juvenile Supplemental Application

PLAN INFORMATION

Product Name _____ Amount of Insurance Applied for $ _____

Risk/Rate Class Applied For:

❑ Standard or Best Available Risk Class

❑ Substandard Risk Class Proposed: Table _____

❑ UL Option 1 Level Death Benefit ❑ UL Option 2 Specified Amount plus Accumulation Value

❑ Term Period _____ years

Rider Name Rider Amount

_____

_____

_____

_____

Applying for a Universal Life plan includes, at no upfront cost, an Accelerated Death Benefit Rider. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. If accelerated death benefits are requested, a discount and $100 charge will be associated with each acceleration request.

Method of Payment : ❑ Monthly Bank Service Plan ❑ Annual ❑ Semiannual ❑ Quarterly

Planned Modal Premium $ _____ Initial Collected Premium $ _____

OWNER

Complete Policyowner information if Proposed Insured is not the Policyowner

Name of Policyowner _____ Date of Birth _____

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

Citizenship Country _____ Phone No. _____

Policyowner Address _____
Street City State ZIP

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

Name _____

Mailing Address _____
Street City State ZIP

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

BENEFICIARY

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

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

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

OTHER COVERAGE INFORMATION

1. Have you or any person proposed for insurance been offered cash, or any other consideration for obtaining this policy?	❑ **Yes** ❑ **No**
2. Are you or any Proposed Insured planning to enter into a finance arrangement to pay any premium payments due under this policy?	❑ **Yes** ❑ **No**
3. Do you or any person proposed for insurance intend to sell or transfer ownership to a third party in the next five years, or have you sold or transferred ownership of a policy to a third party in the last five years? **If "Yes" to questions 1, 2 or 3, provide information in Comments section.**	❑ **Yes** ❑ **No**
4. List below all life insurance policies and/or annuity contracts on any person proposed for insurance that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt.) If none, check the following box	❑ **None**
5. Has any person proposed for insurance had, or intend to have, any life insurance policies, or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application? **Please complete the box(es) below. The Producer shall comply with any additional state, and/or Company replacement requirements.**	❑ **Yes** ❑ **No**

Company	Policy or Contract Number	Face Amount	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
					❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	
					❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	
					❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	
					❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	
					❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	

COMMENTS

Provide any additional information necessary and the details of "Yes" answers. Always identify question number. Attach a sheet for additional details.

_____

_____

_____

_____

_____

_____

_____

RIDER ON OTHER PROPOSED INSURED

Other Proposed Insured Legal Name _____

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

Date of Birth _____ State of Birth _____ Annual Income _____

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

Legal Residence Address _____

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

If Other Proposed Insured is age 0-17 also complete Juvenile Supplemental Application

Occupation/Duties _____ Employer _____

Primary Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

Contingent Beneficiary	% of Proceeds	Relationship to Insured	Date of Birth

If more space is needed, provide information in Comments section

Companion Life Insurance Company
A Mutual *of* Omaha Company
888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

Mutual of Omaha

PART 1B, PAGE 1 OF 1 LIFE INSURANCE APPLICATION

NON-MEDICAL UNDERWRITING

	Proposed Insured	Other Proposed Insured Rider
1. Are the persons proposed for insurance citizens of the United States? . . . . . **If "No," complete the Foreign National and Foreign Travel questionnaire.**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
2. Has any person proposed for insurance ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy? **If "Yes," to question 2, please list details below.**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

Person Proposed for Insurance	Form of Tobacco/Nicotine Replacement Therapy	Number per Day	Date Stopped

3. Has any person proposed for insurance: **If answered "Yes," please list details in the Comments section.**		
(a) had life insurance coverage declined, postponed, or limited, or been denied reinstatement, or asked to pay extra premium by any insurance company?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(b) engaged in any hazardous sports, or activities within the last three years, such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, skydiving, skin diving or scuba diving, cliff diving, base jumping or bungee jumping, or plan such activity in the next two years?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(c) any intention of traveling, or living outside the USA, or Canada in the next two years? **If "Yes," complete the Foreign National and Foreign Travel questionnaire.**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(d) flown as a civilian pilot, student pilot, or crew member within the last three years, or plan such activity in the next two years? **If "Yes," complete the Aviation questionnaire.**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(e) within the last five years (1) been convicted of two or more moving violations, or (2) been convicted of driving under the influence of alcohol, or drugs, or (3) had a driver's license suspended, or revoked?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(f) been convicted of a felony?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(g) been on probation within the last 12 months, or are currently on probation?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

FINANCES

4. Has any person proposed for insurance ever filed for bankruptcy?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

If "Yes," please provide type(s) and date(s) _____

5. What is the purpose of this insurance (e.g., income replacement, mortgage protection, key person, buy-sell)?

_____

6. **If applying for $500,000 or more,** complete box(es) below.

Person Proposed for Insurance	Total Assets	Total Liabilities	Net Worth	Earned Income	Unearned Income

FAMILY HISTORY

7. **Family History – Please list details below for both Proposed Insured and Other Proposed Insured (if applicable), or if not applicable check here** ❑

	Age at Death	**Age at Death**	**If Deceased, Cause of Death**	
	Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				

COMPANION LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY
888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788

MUTUAL of OMAHA

PART 2, PAGE 1 OF 3 LIFE INSURANCE APPLICATION

MEDICAL UNDERWRITING

	Proposed Insured	Other Proposed Insured Rider
1. Does any person proposed for insurance currently have a personal physician?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

Person Proposed for Insurance	Name, Address and Telephone Number of Personal Physician	Date last seen	State Reason, Findings and Treatment

2. Has any person proposed for insurance ever been diagnosed or treated as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) by a member of the medical profession?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
3. Has any person proposed for insurance ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:		
(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, or shortness of breath?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(g) any disease, or disorder of vision, or hearing?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/ metabolic disorder excluding HIV tests?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
4. **In the past 10 years,** has any person proposed for insurance		
(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a physician, or other health care provider?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
5. **In the past 12 months**, has any person proposed for insurance:		
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(b) received, or been advised to have, any of the following types of care: nursing home, assisted living facility, adult day care facility, home health care services, or physical, occupational, or speech therapy?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

MEDICAL UNDERWRITING

	Proposed Insured	Other Proposed Insured
6. In the past two years, has any person proposed for insurance, (a) been prescribed medication, or (b) taken any medication prescribed by a physician, or (c) regularly used over-the-counter medication? . . . . . If answered "Yes," please list details below. If more space is needed use the Comments section.	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date Last Taken	Prescribing Physician (if any)	Reason	Dosage / Frequency

7. In the past five years, has any person proposed for insurance consulted with a doctor or been hospitalized or treated by a health care provider for any other health condition? If answered "Yes," please list details below. If more space is needed use the Comments section.	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

Person Proposed for Insurance	Medical Impairment, Injury, Illness or Results of Testing or Examinations (If operation was performed, state type)	Month and Year	Duration	Degree of Recovery	Name, Address, ZIP and Telephone Number of Hospital, and/or Attending Physician

COMMENTS

List details of "Yes" answers. Identify question number and circle applicable items: Include diagnosis, dates, prescription medications, duration, and names and addresses of all attending physicians and medical facilities. Use and attach an additional sheet of paper if necessary.

AGREEMENT

Each of the undersigned certify that we have read the completed application. We, the undersigned, agree to the following:

1. All answers and statements in this application are true and complete to the best of our knowledge and belief. Companion Life Insurance Company ("Companion") will rely on the answers and statements in the application as the basis for any policy issued. **I, the applicant, understand that no coverage will be issued if the age of the proposed insured or the face amount applied for do not meet the underwriting standards that apply to this policy.**
2. Coverage under the policy will become effective only if and when (a) the full initial premium is paid, (b) Companion has been notified of any change since the date of the application in either the health or habits of any person proposed for insurance, and (c) the policy is delivered and all delivery requirements are fulfilled, including a signed good health statement, if required, during the lifetime of the proposed insured.
3. If there is a change in any proposed insured's health or habits before a policy is delivered, and the change will alter any statement or answer to any question in the application, the applicant or the proposed insured will immediately notify Companion. If the person proposed for insurance is not eligible for the insurance applied for, no policy of any kind will be in effect.
4. The proposed insured or applicant has received the MIB, Inc. Pre-Notice, the Notice of Information Practices, and Life Insurance Buyer's Guide before completing this application.
5. If the applicant is other than the proposed insured, the applicant will own the policy.
6. If the mode of payment is Bank Service Plan, the applicant authorizes premiums due to be automatically paid to Companion by electronic fund transfer until this authorization is cancelled in writing.
7. No producer can (a) waive or change any receipt or policy provision, or (b) agree to issue a policy.
8. The application includes Parts 1 and 2; supplemental forms; and all amendments specifically made a part of the application and signed by the applicant. This application is to be attached to and made a part of the policy.
9. A telephone call in conjunction with the application will or may be used.

I/We have read and understand (a) the Authorization to Receive Information From and Disclose Information to the MIB, Inc. ("MIB"), (b) the Authorization to Disclose Personal Information, and (c) the Agreement section. I/We agree that all answers and statements in this application are true and complete to the best of our knowledge and belief.

Signed at: _____ _____ Date _____
City State Mo Day Yr

_____
Signature of Applicant/Owner/Proposed Insured Age 14½ and over.

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

_____
Signature of Other Proposed Insured age 14½ and over .

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

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

_____
Signature of Parent or Guardian if Proposed Insured is under Age 14½.

PRODUCER STATEMENT:

1. Has any person proposed for insurance informed you, the producer(s), that he/she has one or more existing life insurance policies and/or annuity contracts in force? . . . . . ❑ **Yes** ❑ **No**
2. Do you, the producer(s), know or have reason to believe that the policy applied for has replaced or will replace any existing life insurance policies or annuity contracts? . . . . . ❑ **Yes** ❑ **No**
3. I/We certify that, during an interview with the proposed insured, I/we asked each question exactly as written and recorded the answers provided by the proposed insured(s) completely and accurately. ❑ **Yes** ❑ **No**
4. I conducted said interview in person ❑ **Yes** ❑ **No** If "No," please explain _____

_____

_____

_____ Date _____
Signature of Producer Mo Day Yr

_____ Date _____
Signature of Producer Mo Day Yr

Companion Life Insurance Company
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888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

Additional Information to Expedite Claim Processes

Proposed Insured/Owner/Applicant Name: _____

Please provide below any additional information not already provided on the application.

Beneficiary(ies) listed on Application

Name:_____ Social Security or Tax I.D. Number:_____

Address: _____ Date of Birth: _____ / _____ / _____

City / St / ZIP:_____ Telephone: _____

Name:_____ Social Security or Tax I.D. Number:_____

Address: _____ Date of Birth: _____ / _____ / _____

City / St / ZIP:_____ Telephone: _____

Name:_____ Social Security or Tax I.D. Number:_____

Address: _____ Date of Birth: _____ / _____ / _____

City / St / ZIP:_____ Telephone: _____

If more space is needed, please provide additional page(s)

SUBMIT WITH APPLICATION

Companion Life Insurance Company
A Mutual *of* Omaha Company

Producer Report

(Must be completed by the Producer who obtained the application on the Proposed Primary Insured named below.)

1. Is Proposed Primary Insured self-supporting? ❑ **Yes** ❑ **No**

If "No," provide the following information about the person on whom Proposed Primary Insured is dependent:

Full Name_____ Address _____ Birth Date _____

Amount of life insurance carried with all companies $ _____ If none, state why _____

2. If Proposed Primary Insured used a different name in past, give previous different full name(s)_____

_____

3. Are you related to the Proposed Primary Insured or Owner? ❑ **Yes** ❑ **No**
If answered "Yes," state relationship _____

4. How long have you known the Proposed Primary Insured? _____

5. How long have you known the Proposed Owner? _____

6. Have you, the producer, observed or are you aware of any additional information that may affect the issuance of this policy? If "Yes," explain below ❑ **Yes** ❑ **No**

_____

_____

_____

7. Will any entity other than a life insurance company evaluate the Proposed Life Insured(s) medically to determine life expectancy or to otherwise obtain financing? ❑ **Yes** ❑ **No** If "Yes," provide details

_____

_____

_____

8. Will there be a rebate of any kind, such as a rebate of premium, to the Proposed Insured or Proposed Owner? ❑ **Yes** ❑ **No**

9. Rate class quoted _____

10. Please check the Underwriting requirements ordered: ❑ Blood Profile/HOS ❑ Inspection Report ❑ MD Exam ❑ Treadmill EKG ❑ EKG ❑ Paramedical Exam Paramed Company _____

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

Address	From	To

Additional Comments

_____

_____

Division Office/Brokerage General Agency/Bank Information

Printed Name of Producer	Printed Name of Producer
Commission % Share	Commission % Share
Phone No.	Phone No.
E-mail Address	E-mail Address
Date	Date

PLEASE SUBMIT ALL PAGES

Companion Life Insurance Company

A Mutual *of* Omaha Company

888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

Conditional Receipt

This Conditional Receipt ("Receipt") requires that the applicant submit a check or provide the authorization and account number to pay the first modal premium.

❑ A check dated _____ for $_____ from _____
Mo Day Yr

covering the lives of _____accompanies this Receipt.
(Person(s) Proposed for Insurance)

❑ An authorization and account number to pay the first modal premium accompanies this Receipt.

ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO COMPANION LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

This Receipt is furnished in connection with an application for insurance on the above proposed insured(s) bearing the same date as this Receipt. Insurance under this Receipt will become effective on the Effective Date defined below, but only if **all** conditions below have been completely met:

(1) The check submitted or the authorization and account number provided is sufficient to pay the first modal premium.

(2) The date of the medical exam, or the date of the second medical exam if required must be completed within 60 days from the date of the application.

(3) Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to Companion Life Insurance Company's published underwriting rules then in effect, without modification of the plan, premium rate, benefits, class and amount of coverage applied for.

(4) To the best knowledge and belief of those signing the application all the statements and answers in the application are true and complete when made.

(5) All parts of the application, and if required, supplements to the application, questionnaires and amendments to the application are completed and received by Companion Life Insurance Company.

If any of the above conditions are not met or if any proposed insured dies by suicide, the liability of Companion Life Insurance Company will be limited to the return of the premium paid.

CONDITIONAL INSURANCE COVERAGE: The amount of conditional insurance coverage provided under this Receipt, if any, shall not exceed $500,000 and shall also not exceed the death benefit applied for. If Companion Life Insurance Company does not approve and accept the application for insurance within 60 days of the Effective Date of this Receipt, conditional insurance coverage will cease. In that case, Companion Life Insurance Company's liability will be limited to the return of the premium paid. Companion Life Insurance Company has the right to terminate conditional insurance coverage at any time prior to the expiration of 60 days of the Effective Date of this Receipt by mailing a refund of the premium paid.

Effective Date: If all the conditions above are met, then insurance under this Receipt, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the later of: (a) the date of application; or (b) the date of completion of all underwriting requirements stated in (2) above.

No producer is authorized to waive or modify any of the provisions of this Receipt.

This Receipt is furnished in connection with an application for insurance bearing the same date as this Receipt. In no event will benefits be paid for the same loss under both the applied for issued policy and this Receipt.

I understand and agree to the terms, conditions and limits of this Receipt.

Signed at: _____ _____ Date _____
City State Mo Day Yr

_____
Signature of Proposed Insured Age 14½ and over

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

_____
Signature of Other Proposed Insured Age 14½ and over

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

_____
Signature of Parent or Guardian
(if Proposed Insured is under age 14½)

Companion Life Insurance Company

888 Veterans Memorial HWY, Suite 515, Hauppauge, NY 11788-2934, 402-342-7600

PAYMENT AUTHORIZATION FORM

Proposed Insured/Insured: _____ Policy Number(s) if known: _____

Complete this form only when authorizing a bank account withdrawal for premium payment.

Payment Information

1. **Initial Monthly Premium Payment (select only one option)** Amount Quoted $_____

☐ Draft premium immediately upon approval/issue

☐ Draft initial premium on or after: _____/_____/_____ (Please Note: If policy issue is after date selected, premium will be withdrawn on the policy issue date or receipt of delivery requirements)

☐ Check collected and mailed to Mutual of Omaha

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT AS STATED ABOVE. The first Withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is issued, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. We **CANNOT** establish electronic payments from foreign banks.

2. **Ongoing Premium Payments**- Automated Bank Account Withdrawal (Monthly)

Specify the date ongoing premiums will be withdrawn: (1st through the 28th of each month) _____

Ongoing premiums are due and will be automatically withdrawn from the account below on the same day of the month as the policy date or the date selected above. The policy date is determined at the time the policy is issued and can be found within the policy. **Ongoing withdrawals will begin once the policy is issued.**

Payor Information

Name of payor as shown on bank account: _____ Social Security No._____

If premium is **NOT** paid by Proposed Insured/Insured, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. (Additional documentation required)

☐ Employer

☐ Business owned by Proposed Insured/Insured or spouse

☐ Power of Attorney or legal guardian

☐ Living Trust

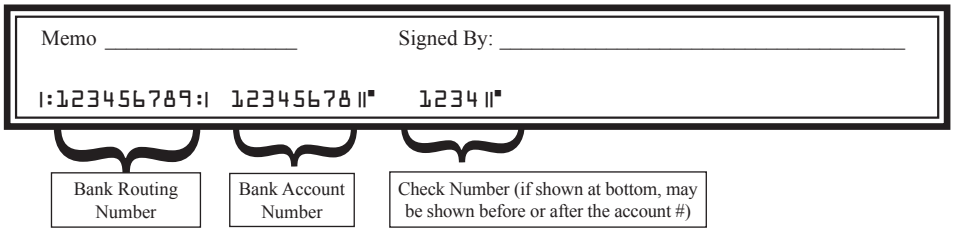
☐ Other _____

Account Information

1. Account Type (check one): ☐ Checking ☐ Savings
2. Name of Financial Institution: _____
3. Complete information below or attach a voided check here.

Bank Routing Number: _____ Bank Account Number: _____

(Do not use Debit/Credit Card numbers)



Authorization

I authorize Companion Life Insurance Company ("Companion") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Companion any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Companion may require written confirmation from me within 14 days after my verbal notice.

Date _____ X _____

Mo./Day/Yr. Authorized Signature as Shown on Account

Companion Life Insurance Company
A Mutual *of* Omaha Company
888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION

This authorization specifically includes the release and disclosure of my "Personal Information," which includes my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

I authorize all hospitals, medical facilities and clinics, physicians, dentists, other medical or dental practitioners, pharmacies, pharmacists, pharmacy benefit managers, insurance companies, third party administrators, health plans, health maintenance organizations, state departments of motor vehicles, other entities possessing motor vehicle records and consumer reporting agencies that have records or knowledge of me and my children, if they are proposed insureds (My Children), to release Personal Information about me or My Children to Companion Life Insurance Company (Companion Life), its affiliated companies or its reinsurers.

The Personal Information will be used to determine my and My Children's eligibility for insurance or to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application that may arise during the processing of my application or in connection with a claim.

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

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

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

I understand that I will receive a copy of this authorization and that a copy is as valid as the original.

Each Proposed Insured acknowledges and agrees that if there is more than one Proposed Insured on this application, all information provided may be reviewed or shared with the other Proposed Insured. A completed and signed application will become part of each insured's policy.

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

_____

_____ **Date:** _____
Signature of Proposed Insured Mo Day Yr

_____ **Date:** _____
Signature of Spouse (if Proposed Insured) Mo Day Yr

_____ **Date:** _____
Signature of Parent or Guardian (if Proposed Insured is a Minor) Mo Day Yr

_____ **Date:** _____
Signature of Non-minor Child (if Proposed Insured is a Non-minor) Mo Day Yr

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

Companion Life Insurance Company

A Mutual *of* Omaha Company

888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

Authorization to Receive and Disclose Information to MIB, Inc.

"MIB, Inc." means: a non-profit membership organization of insurance companies which operates an information exchange on behalf of its members.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, and other information such as finances, occupation, general reputation and insurance claims information. Personal Information does not include confidential drug and alcohol treatment information.

I authorize MIB, Inc. to release Personal Information about me and my children under the age of 18, if they are proposed insureds, to Companion Life Insurance Company, its representatives and its reinsurers. MIB, Inc. is not authorized to release Personal Information about me or my children under the age of 18 to any consumer reporting agency. The Personal Information received will assist in verifying the accuracy of the information I have provided in my application(s) for insurance.

I authorize Companion Life Insurance Company or its reinsurers to make a brief report of my personal health information to MIB, Inc. I understand that the Personal Information received by MIB, Inc. may be disclosed, upon request, to another member company with whom I apply for life or health insurance or to whom I submit a claim for benefits or to other persons or organizations as may be otherwise lawfully required or as I may authorize.

I understand that I may request MIB, Inc. to arrange disclosure of any information it may have in my file. If I question the accuracy of information in MIB, Inc.'s file, I may contact MIB, Inc. and seek correction. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 and the telephone number is 866-692-6901, TTY: 866-346-3642 for hearing impaired.

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

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

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

Authorization to Receive and Disclose Drug and Alcohol Treatment Information to MIB, Inc.

"MIB, Inc." means: a non-profit membership organization of insurance companies which operates an information exchange on behalf of its members**.**

I authorize MIB, Inc. to release to representatives of Companion Life Insurance Company confidential drug and alcohol treatment information about me and my children under the age of 18, if they are proposed insureds. I also authorize Companion Life Insurance Company to disclose my or my minor's child's identity, diagnosis, or treatment information which are maintained in connection with any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research.

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

_____

_____ Date _____

Signature of Proposed Insured Mo Day Yr

_____ Date _____

Signature of Other Proposed Insured Mo Day Yr

_____ Date _____

Signature of Parent or Guardian Mo Day Yr
(If Any Proposed Insured is a minor under age 18)

Companion Life Insurance Company
A Mutual *of* Omaha Company
888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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

DISCLOSURE FOR TERM LIFE INSURANCE POLICIES

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

BENEFIT DESCRIPTION

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit up to $1,000,000 or 80% of the policy's death benefit, whichever is less. Terminal Illness means the insured has been certified by a physician as having a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date of certification.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a $100 charge. The actuarial discount rate will not be greater than 6%.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay the accelerated death benefit, the policy will continue with a reduced face amount and a reduced premium.

DISCLOSURE FOR UNIVERSAL LIFE INSURANCE POLICIES

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

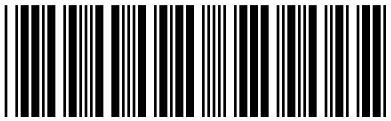
BENEFIT DESCRIPTION – ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit. The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

Terminal Illness means the insured has been certified by a physician as having a medical condition that, with a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date of certification.
We will reduce the Terminal Illness benefit by an actuarial discount rate and a $100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount will be determined as of the date of the requested acceleration and will not exceed the lesser of:

(a) 6%; and
(b) the greater of:
    1. the then current yield on the 90-day Treasury Bills
    2. the then current maximum adjustable policy loan interest rate based on the greater of:
        (i) Moody's Corporate Bond Yield Averages and
        (ii) the policy's guaranteed minimum interest rate plus one per cent per annum (1%).

BENEFIT DESCRIPTION – ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER



Notice to Buyer: This rider may not cover all the costs associated with the Chronic Illness of the insured. You are advised to review the rider benefits carefully.

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means the insured has been certified by a licensed health care practitioner within the last 12 months as:

(a) being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a continuous period of at least 90 days due to a loss of functional capacity; or

(b) requiring substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

The sum of all requested accelerations may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration. Each requested acceleration may not result in a Chronic Illness benefit, calculated before subtracting any amount applied to an outstanding loan, that exceeds:

(a) the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code; multiplied by

(b) the number of days in the current calendar year that the insured is Chronically Ill.

The Internal Revenue Service announces the per diem limit for each calendar year.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by an actuarial discount rate multiplied by the insured's life expectancy in years, a $100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount will be determined as of the date of the requested acceleration and will not exceed the lesser of:

(a) 6%; and

(b) the greater of:

1. the then current yield on the 90-day Treasury Bills
2. the then current maximum adjustable policy loan interest rate based on the greater of:
   (i) Moody's Corporate Bond Yield Averages and
   (ii) the policy's guaranteed minimum interest rate plus one per cent per annum (1%).

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay any accelerated death benefit, the following will occur:

(a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the death benefit; and

(b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.

ACKNOWLEDGMENT

I acknowledge receipt of this disclosure form.

_____ _____

Applicant/Owner Signature Date

I have provided this disclosure form to the applicant.

_____ _____

Producer Signature Date

Mutual of Omaha Insurance Company
Companion Life Insurance Company
A Mutual *of* Omaha Company

Please check appropriate underwriting company

☐ **Mutual of Omaha Insurance Company** ☐ **Companion Life Insurance Company**

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance, you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, 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 or other designee for reporting a positive test result _____

_____

Address _____

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

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. This form will not attach to or become part of the policy.

Name of Proposed Insured _____

Address _____

_____

Signature of Proposed Insured or Parent/Guardian if under age 18

_____

Date Signed

PLEASE SUBMIT

Companion Life Insurance Company
A Mutual *of* Omaha Company
888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

Department of Financial Services of the State of New York
Definition of Replacement

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent or broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

(1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated?
Yes ☐ No ☐

(2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values?
Yes ☐ No ☐

(3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force?
Yes ☐ No ☐

(4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?
Yes ☐ No ☐

(5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?
Yes ☐ No ☐

(6) Continued with a stoppage of premium payments or reduction in the amount of premium paid?
Yes ☐ No ☐

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Regulation 60 has occurred or is likely to occur and your agent or broker is required to provide you with the **Important** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts. You will also receive a completed Disclosure Statement no later than the time your policy or new contract is delivered.

Date: _____ **Signature of Applicant:** _____

Date: _____ **Signature of Applicant:** _____

To the best of my knowledge, a replacement is involved in this transaction: Yes ☐ No ☐

Date: _____ **Signature of Agent or Broker:** _____

Y5415_0415

Company's Copy

Client Copies

Please provide the client with the following forms. They do not need to be signed.

Except:

Definition of Replacement Form – Y5415_04/3
You and the applicant must sign the customer copy of the Definition of Replacement Form.

Additional Instructions:
Remove the following forms and do not provide them to the client.

Conditional Receipt – Do not provide the conditional receipt to the client if money was not collected.

Companion Life Insurance Company

A Mutual *of* Omaha Company

888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

Conditional Receipt

This Conditional Receipt ("Receipt") requires that the applicant submit a check or provide the authorization and account number to pay the first modal premium.

❑ A check dated _____ for $_____ from _____
Mo Day Yr

covering the lives of _____accompanies this Receipt.
(Person(s) Proposed for Insurance)

❑ An authorization and account number to pay the first modal premium accompanies this Receipt.

ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO COMPANION LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

This Receipt is furnished in connection with an application for insurance on the above proposed insured(s) bearing the same date as this Receipt. Insurance under this Receipt will become effective on the Effective Date defined below, but only if **all** conditions below have been completely met:

(1) The check submitted or the authorization and account number provided is sufficient to pay the first modal premium.

(2) The date of the medical exam, or the date of the second medical exam if required must be completed within 60 days from the date of the application.

(3) Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to Companion Life Insurance Company's published underwriting rules then in effect, without modification of the plan, premium rate, benefits, class and amount of coverage applied for.

(4) To the best knowledge and belief of those signing the application all the statements and answers in the application are true and complete when made.

(5) All parts of the application, and if required, supplements to the application, questionnaires and amendments to the application are completed and received by Companion Life Insurance Company.

If any of the above conditions are not met or if any proposed insured dies by suicide, the liability of Companion Life Insurance Company will be limited to the return of the premium paid.

CONDITIONAL INSURANCE COVERAGE: The amount of conditional insurance coverage provided under this Receipt, if any, shall not exceed $500,000 and shall also not exceed the death benefit applied for. If Companion Life Insurance Company does not approve and accept the application for insurance within 60 days of the Effective Date of this Receipt, conditional insurance coverage will cease. In that case, Companion Life Insurance Company's liability will be limited to the return of the premium paid. Companion Life Insurance Company has the right to terminate conditional insurance coverage at any time prior to the expiration of 60 days of the Effective Date of this Receipt by mailing a refund of the premium paid.

Effective Date: If all the conditions above are met, then insurance under this Receipt, subject to all the terms and conditions of the policy applied for and as if the policy applied for had already been issued and delivered, will become effective on the later of: (a) the date of application; or (b) the date of completion of all underwriting requirements stated in (2) above.

No producer is authorized to waive or modify any of the provisions of this Receipt.

This Receipt is furnished in connection with an application for insurance bearing the same date as this Receipt. In no event will benefits be paid for the same loss under both the applied for issued policy and this Receipt.

I understand and agree to the terms, conditions and limits of this Receipt.

Signed at: _____ _____ Date _____
City State Mo Day Yr

_____
Signature of Proposed Insured Age 14½ and over

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

_____
Signature of Other Proposed Insured Age 14½ and over

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

_____
Signature of Parent or Guardian
(if Proposed Insured is under age 14½)

Companion Life Insurance Company
A Mutual *of* Omaha Company
888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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

DISCLOSURE FOR TERM LIFE INSURANCE POLICIES

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

BENEFIT DESCRIPTION

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit up to $1,000,000 or 80% of the policy's death benefit, whichever is less. Terminal Illness means the insured has been certified by a physician as having a medical condition that, within a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date of certification.

We will reduce the Terminal Illness benefit by an actuarial discount rate and a $100 charge. The actuarial discount rate will not be greater than 6%.

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay the accelerated death benefit, the policy will continue with a reduced face amount and a reduced premium.

DISCLOSURE FOR UNIVERSAL LIFE INSURANCE POLICIES

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

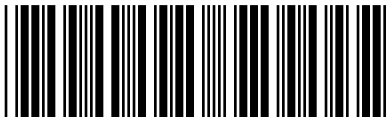
BENEFIT DESCRIPTION – ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

If the insured is diagnosed as having a Terminal Illness while the policy is in force, you may make a one-time election to receive an accelerated death benefit. The sum of all requested accelerations under the Terminal Illness Rider and the Chronic Illness Rider may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration.

Terminal Illness means the insured has been certified by a physician as having a medical condition that, with a reasonable degree of medical certainty, will result in the insured's death within 12 months or less from the date of certification.
We will reduce the Terminal Illness benefit by an actuarial discount rate and a $100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount will be determined as of the date of the requested acceleration and will not exceed the lesser of:

(a) 6%; and
(b) the greater of:
    1. the then current yield on the 90-day Treasury Bills
    2. the then current maximum adjustable policy loan interest rate based on the greater of:
        (i) Moody's Corporate Bond Yield Averages and
        (ii) the policy's guaranteed minimum interest rate plus one per cent per annum (1%).

BENEFIT DESCRIPTION – ACCELERATED DEATH BENEFIT FOR CHRONIC ILLNESS RIDER



Notice to Buyer: This rider may not cover all the costs associated with the Chronic Illness of the insured. You are advised to review the rider benefits carefully.

If the insured is diagnosed as being Chronically Ill while the policy is in force, you may elect to receive an accelerated death benefit.

Chronically Ill means the insured has been certified by a licensed health care practitioner within the last 12 months as:

(a) being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a continuous period of at least 90 days due to a loss of functional capacity; or

(b) requiring substantial supervision to protect himself or herself from threats to health and safety due to severe cognitive impairment.

The sum of all requested accelerations may not exceed the lesser of $1,000,000 or 80% of the specified amount as of the date of the first requested acceleration. Each requested acceleration may not result in a Chronic Illness benefit, calculated before subtracting any amount applied to an outstanding loan, that exceeds:

(a) the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code; multiplied by

(b) the number of days in the current calendar year that the insured is Chronically Ill.

The Internal Revenue Service announces the per diem limit for each calendar year.

You may elect to receive the Chronic Illness benefit more than once, and there must be at least 12 months between acceleration requests. In contrast, you may elect to receive the Terminal Illness benefit only once. If you elect to receive the Terminal Illness benefit, the Chronic Illness benefit is no longer available.

We will reduce the Chronic Illness benefit by an actuarial discount rate multiplied by the insured's life expectancy in years, a $100 charge, and the pro-rated amount of any outstanding loans. The actuarial discount will be determined as of the date of the requested acceleration and will not exceed the lesser of:

(a) 6%; and

(b) the greater of:

1. the then current yield on the 90-day Treasury Bills
2. the then current maximum adjustable policy loan interest rate based on the greater of:
   (i) Moody's Corporate Bond Yield Averages and
   (ii) the policy's guaranteed minimum interest rate plus one per cent per annum (1%).

EFFECT OF THE ACCELERATED DEATH BENEFIT ON THE POLICY

When we pay any accelerated death benefit, the following will occur:

(a) we will reduce the specified amount, accumulation value, and any loan by the same proportion as the death benefit; and

(b) the monthly deduction and cost of insurance charge will be based on the reduced specified amount.

ACKNOWLEDGMENT

I acknowledge receipt of this disclosure form.

_____ _____

Applicant/Owner Signature Date

I have provided this disclosure form to the applicant.

_____ _____

Producer Signature Date

Mutual of Omaha Insurance Company
Companion Life Insurance Company
A Mutual *of* Omaha Company

Please check appropriate underwriting company

☐ **Mutual of Omaha Insurance Company** ☐ **Companion Life Insurance Company**

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

To determine your insurability, the Insurer named above (the Insurer) has requested that you provide a sample of your blood and/or other bodily fluid for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance, you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done, except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. For those reasons, a person with a positive test result may wish to consider further independent testing.

Positive HIV antibody or antigen test results or other significant blood abnormalities 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.

Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, 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 or other designee for reporting a positive test result _____

_____

Address _____

If you desire further information about AIDS, the meaning or HIV-related test results and the availability and location of HIV-related counseling services, you may call the New York State Department of Health on their toll-free number 1-800-541-AIDS.

Consent

I have read and I understand this Notice and Consent for AIDS-related Testing. I voluntarily consent to the withdrawal of blood and/or other bodily fluids from me, the testing of that blood and/or other bodily fluids, and the disclosure of the test results as described herein.

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. This form will not attach to or become part of the policy.

Name of Proposed Insured _____

Address _____

_____

Signature of Proposed Insured or Parent/Guardian if under age 18

_____

Date Signed

GIVE THIS COPY TO THE APPLICANT

Companion Life Insurance Company
A Mutual *of* Omaha Company
888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

Department of Financial Services of the State of New York
Definition of Replacement

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent or broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

(1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated?
Yes ☐ No ☐

(2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values?
Yes ☐ No ☐

(3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force?
Yes ☐ No ☐

(4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?
Yes ☐ No ☐

(5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?
Yes ☐ No ☐

(6) Continued with a stoppage of premium payments or reduction in the amount of premium paid?
Yes ☐ No ☐

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Regulation 60 has occurred or is likely to occur and your agent or broker is required to provide you with the **Important** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts. You will also receive a completed Disclosure Statement no later than the time your policy or new contract is delivered.

Date: _____ **Signature of Applicant:** _____

Date: _____ **Signature of Applicant:** _____

To the best of my knowledge, a replacement is involved in this transaction: Yes ☐ No ☐

Date: _____ **Signature of Agent or Broker:** _____

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Companion Life Insurance Company

888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788

MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Companion Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, 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, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 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 is: 50 Braintree Hill Park, Suite 400, Braintree, MA 01284-8734.

Companion Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Fair Credit Reporting Act Disclosure Statement

Mutual of Omaha Insurance Company and/or Companion Life Insurance Company, or its/their duly authorized representative(s), may request and obtain an investigative consumer report for the purpose of serving as a factor in the underwriting of your insurance application.

An investigative consumer report means any written, oral or other communication of any information by a consumer reporting agency bearing on your character, general reputation, personal characteristics or mode of living obtained through personal interviews with your neighbors, friends, acquaintances, associates, or those who may have knowledge concerning such items of information.

Upon written request, we will inform you whether or not an investigative consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. Upon furnishing you with the name and address of the consumer reporting agency to whom the request was made, you shall also be informed you may inspect and receive a copy of such report by contacting such agency.

If you request the additional disclosures from either Companion Life Insurance Company or Mutual of Omaha Insurance Company, please send your request to the following address: Attention: Individual Underwriting Department, Mutual of Omaha Plaza, Omaha, Nebraska 68175.

Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate. In the event of an adverse underwriting decision, our Company will provide in writing the specific reason for the underwriting decision.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: COMPANION LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

Investigative Consumer Reports Notice

Companion Life Insurance Company ("we") may request that an investigative consumer report be prepared, whereby information about you is obtained through personal interviews with your neighbors, friends, associates, acquaintances or others who may have knowledge relating to your character, general reputation, personal characteristics, or mode of living. Upon request, we will inform you whether an investigative consumer report was done, and the nature and scope of the investigation. You may request to be interviewed in connection with the preparation of an investigative consumer report. You also have the right, upon request, to receive a copy of the investigative consumer report from the consumer reporting agency that prepared it. We will provide you the name, address and telephone number of the consumer reporting agency so that you may request a copy of any such report directly from the agency. You may question the accuracy or seek correction of information contained in such report.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
  - a person has taken adverse action against you because of information in your credit report;
  - you are the victim of identify theft and place a fraud alert in your file;
  - your file contains inaccurate information as a result of fraud;
  - you are on public assistance;
  - you are unemployed but expect to apply for employment within 60 days.

  In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 1-202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 1-800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 1-703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation , Office of Financial Management Washington, DC 20590 1-202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator - GIPSA Washington, DC 20250 1-202-720-7051

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GIVE THIS COPY TO THE APPLICANT