Companion Life Insurance Company
A Mutual *of* Omaha Company

New York– Application for Life Insurance

Living Promise Product – 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
FAX: 1-402-997-1800

☞ Please choose the precise Plan, Rider, and amount of insurance applied for

❑ **Level Benefit Product:**	❑ **Graded Benefit Product (if available):**
• Accelerated Death Benefit Rider • Accidental Death Benefit Rider (optional)	• No Riders Available

Application Submission Guidelines

- ❑ Attach a cover letter or additional information as needed.
- ❑ Always submit the Producer Report page.
- ❑ Leave all applicable forms and Life Buyer's Guide with the Proposed Insured.
- ❑ 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.

Important Forms

- ❑ Replacement Notice – if applicable, the client must sign and retain a copy for their records
- ❑ Payment Authorization – Complete this form if applicable
- ❑ Conditional Receipt – Complete ONLY if you accepted a check or electronic transaction authorization at time of application for the initial premium. **DO NOT** complete the Conditional Receipt if initial payment won't be collected until issue.
- ❑ Accelerated Benefit Rider Disclosure – The client must sign the Accelerated Benefit Rider Disclosure Form
- ❑ Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor - Complete this form if applicable. The client must sign and retain a copy for their records.

Supplemental Forms and Buyer's Guide:

- ***Buyer's Guide:*** For all life products, the shopping guide for insurance is to be given to the consumer at point of sale.

Companion Life Insurance Company

888 Veterans Memorial HWY, Suite 515
Haupppauge, NY 11788-2934

Mutual of Omaha

Application for Individual Life Insurance

PROPOSED INSURED

Name (First, Middle Initial, Last)	Sex ☐ Male ☐ Female	Height	Weight	Social Security No.

Home Address (Street, City, State, Zip)	State of Birth	Date of Birth	Age

Phone No.	E-mail	Driver's License No.	Driver's License State

Are you a legal resident of the United States? ☐ **Yes** ☐ **No** **(if "No", you are not eligible for coverage)**	**In the past 12 months**, has the Proposed Insured used any form of tobacco or nicotine replacement therapy? ☐ **Yes** ☐ **No**

OWNER (Complete only if Owner/Applicant is different from Proposed Insured)

Name of Policyowner (First, Middle Initial, Last)	Relationship to Proposed insured

Policyowner Address (Street, City, State, Zip)	Phone No.	Social Security No.

Sex ☐ Male ☐ Female	Date of Birth	Age	E-mail	Citizenship Country

UNDERWRITING

Part One **IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTIONS IN PART ONE, THAT PERSON IS NOT ELIGIBLE FOR ANY COVERAGE UNDER THIS APPLICATION.**

To the best of your knowledge and belief:

1. Is the Proposed Insured currently: **(a)** bedridden or confined to any hospital, nursing home, long-term care facility or skilled nursing facility; or receiving or been advised to receive care in a nursing home, hospice care, or home health care? . . . . **(b)** requiring assistance with activities of daily living such as taking medications, bathing, dressing, eating, toileting, getting in and out of a chair or bed, or control of bowel or bladder problems? . . . . . . **(c)** requiring any of the following (other than for fractures, bone or joint surgery, including replacement): wheelchair, electric scooter, or oxygen equipment to assist breathing (excluding use for sleep apnea)?	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
2. Has the Proposed Insured **ever been**: **(a)** diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or heath care provider?. . . . . . **(b)** diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Quadriplegia, Paraplegia, Down's Syndrome, mental incapacity, congestive heart failure, Cirrhosis, Metastatic Cancer or recurrent Cancer of the same type? . . . . . . **(c)** diagnosed with insulin shock, diabetic coma, or had an amputation due to diabetic complications or diagnosed with End Stage Renal Disease or requiring dialysis?. . . . . . **(d)** advised to receive or have received an organ or bone marrow transplant?. . . . . . **(e)** diagnosed by a physician or health care provider as having a terminal medical condition that is expected to result in death within the next twelve (12) months?.	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
3. In the past 12 months, has the Proposed Insured been: **(a)** advised by a physician to have a surgical operation, diagnostic testing other than for routine screening purposes or for those related to HIV/AIDS, treatment, hospitalization, or other procedure which has not been done or for which results are not known? . . . . . . **(b)** diagnosed by a physician or health care provider as having heart disease or heart surgery of any kind? . .	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. In the past 2 years, has the Proposed Insured been diagnosed with, been treated for or advised by a physician or health care provider to receive treatment for any form of cancer (except basal or squamous cell skin cancer)?	☐ **Yes** ☐ **No**

Part Two	IF THE PROPOSED INSURED ANSWERS "YES" TO ANY QUESTION IN PART TWO, THAT PERSON IS ELIGIBLE ONLY FOR THE GRADED BENEFIT PRODUCT.	
5.	Has the Proposed Insured **ever** (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
	(a) Diabetes before age 50 or diabetes at any age with complications of Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve) or Peripheral Vascular Disease (PVD or PAD)?	☐ **Yes** ☐ **No**
	(b) Hepatitis C?	☐ **Yes** ☐ **No**
	(c) Chronic Lung Disease, including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, or Sarcoidosis?	☐ **Yes** ☐ **No**
6.	**In the past 4 years**, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
	(a) Cancer, Leukemia, Melanoma or any other internal cancer (except basal or squamous cell skin cancer)?	☐ **Yes** ☐ **No**
	(b) Chronic Kidney Disease, Systemic Lupus or Scleroderma?	☐ **Yes** ☐ **No**
	(c) Bipolar Depression, Schizophrenia, Parkinson's Disease or Multiple Sclerosis?	☐ **Yes** ☐ **No**
7.	**In the past 2 years**, has the Proposed Insured: (a) received care or treatment for, or (b) been advised by a physician or health care provider to seek treatment for:	
	(a) Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Cardiomyopathy, irregular heart rhythm, or Valvular Heart Disease with surgical repair or replacement?	☐ **Yes** ☐ **No**
	(b) Stroke or Transient Ischemic Attack (TIA)?	☐ **Yes** ☐ **No**
8.	**In the past 2 years**, has the Proposed Insured:	
	(a) been convicted of or currently awaiting trial for a felony?	☐ **Yes** ☐ **No**
	(b) been treated for or advised to have treatment for alcohol or drug abuse or convicted more than once of reckless driving or driving under the influence of drugs or alcohol?	☐ **Yes** ☐ **No**
	(c) used unlawful drugs in any form or abused or misused prescription drugs?	☐ **Yes** ☐ **No**
9.	**In the past 2 years**, has the Proposed Insured been hospitalized by a physician or health care provider for any mental or nervous disorder?	☐ **Yes** ☐ **No**
10.	**In the past 12 months,** has the Proposed Insured consulted a physician for chronic cough, unexplained weight loss greater than 10 pounds, fatigue or unexplained gastrointestinal bleeding?	☐ **Yes** ☐ **No**

NOTE: If the Proposed Insured answers all above questions "No", that person is eligible for the Level Benefit Product.

OPTIONAL COMMENTS (Not Required) - Provide any additional information available.

Question Number	Details to Underwriting Questions (Diagnosis, Dates, Durations, Medications, Dosages)

Plan:	Rider: (Only if selecting Level Benefit Product)
☐ Level Benefit Product ☐ Graded Benefit Product Amount Applied For $ _____	☐ Accidental Death Rider

Payment Mode:

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (Automated Bank Account Withdrawal)

Modal Premium $_____ Collected Premium $_____

BENEFICIARY (If more space is needed, list on a separate sheet)

Primary Beneficiary	Relationship to Insured	Date of Birth
Address	Social Security No.	Phone No.
Contingent Beneficiary	Relationship to Insured	Date of Birth
Address	Social Security No.	Phone No.

OTHER COVERAGE INFORMATION

1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with the company or any other company? . . . . . ☐ **Yes** ☐ **No**

2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with the company or any other company? . . . . . ☐ **Yes** ☐ **No**

If "Yes" to questions #1 or #2, please give details below. If more space is needed, list on a separate sheet.

Company	Proposed Insured	Face Amount	To be Replaced or Converted?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

AGREEMENT

1. This application will be attached to and made a part of the policy. The undersigned agree(s) that (a) all answers in this application are true and complete to the best of my knowledge and belief; (b) Companion Life Insurance Company ("Companion") will rely on these answers to determine insurability.

2. The undersigned acknowledge(s) that Companion may require medical records, an underwriting assessment, a medical examination, or other information.

3. The undersigned agree(s) that Companion will not issue a policy as a result of this application unless (a) the Proposed Insured completes all medical examinations and tests required by Companion; (b) Companion receives any additional information requested for underwriting; and (c) the Proposed Insured is, as of the policy application date, determined to be eligible for the exact insurance applied for, or the Proposed Insured or the Applicant (if other than the Proposed Insured) has subsequently accepted an offer by Companion for coverage other than as applied for, according to the underwriting standards of Companion then in force.

4. The undersigned agree(s) that this application does not provide temporary or interim insurance prior to policy issuance. If the undersigned has made an advance premium payment, undersigned agree(s) to the terms and conditions of the Conditional Receipt. The undersigned agree(s) that completing this application or making an advance premium payment is not a guarantee that this application will be approved. If approved, the issued policy will indicate its effective date. The undersigned acknowledge(s) that if this application is declined, the insurance coverage applied for will not become effective and any advance premium payment submitted with the application will be refunded to the Proposed Insured or the Applicant (if other than the Proposed Insured), without interest. No insurance coverage will be in effect until Companion (a) issues a policy and (b) receives payment of the full initial premium according to the mode of payment specified in the application. Since this policy is issued with minimal or no underwriting, the premium rate charged includes an extra mortality risk charge. If you are healthy enough to qualify as a "standard" risk, premiums would likely have been lower if you had applied for a fully underwritten policy.

5. A completed and signed application will become part of the Proposed Insured's policy or the Applicant's policy (if other than the Proposed Insured).

6. The undersigned acknowledge(s) that no producer can (a) waive or change any receipt or policy provision; or (b) agree to issue a policy.

I have received the MIB, Inc. Pre-Notice, the Notice of Information Practices and a Life Insurance Buyer's Guide before completing this application.

If applying for the Graded Benefit Product: I understand that a reduced death benefit amount is payable during the first two policy years if death results from sickness or other natural causes. The full face amount is payable during the first two policy years if death results from an accident.

I approve the answers to the questions in this application as recorded.

I have read and understand the Authorization to Receive Information form and Disclose Information to MIB, Inc. and the Agreement Section.

Signed at: _____
City State

_____ Date: _____
Signature of Proposed Insured

_____ Date: _____
Signature of Applicant/Owner/Trustee (if Other Than Proposed Insured)

Producer Statement:

By signing below, I/we, the Producer(s), hereby agree that I/we know of nothing detrimental to the risk that is not recorded in this application.

Do you, the Producer(s), have any reason to believe the policy applied for has replaced or will replace any insurance policy or annuity contract in force with the company or any other company? . . . . . ☐ **Yes** ☐ **No**

Has the Proposed Insured informed you, the Producer(s), that he/she has any pending applications or existing life insurance or annuity contracts with the company or any other company?. . . . . ☐ **Yes** ☐ **No**

(If either question is answered "Yes," fulfill all state and company requirements.)

Are you related to the Proposed Insured or Owner? . . . . . ☐ **Yes** ☐ **No**

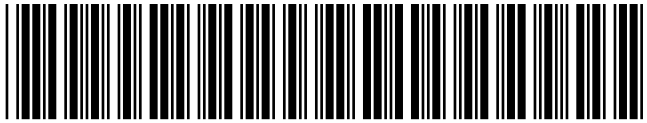
If "Yes," state relationship _____

How long have you known the Proposed Insured? _____

How long have you known the Proposed Owner? _____

_____	_____	_____	_____
Signature of Producer #1	Producer E-mail	Production Number	Date
_____	_____	_____	_____
Signature of Producer #2	Producer E-mail	Production Number	Date

_____	_____	_____
Print Producer #1 Name	Print Producer #2 Name	Agency Name



Producer Report

1 Was a Personal Health Interview (PHI) conducted by Apptical Corporation as a part of the application process?.....☐ Yes ☐ No

If Yes, please provide the PHI number_____

2 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

3 I conducted said interview in person ..... ☐ Yes ☐ No

If "No," please explain _____

_____

4 List any additional information or comments below:

_____

_____

_____

_____

_____

_____

_____

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

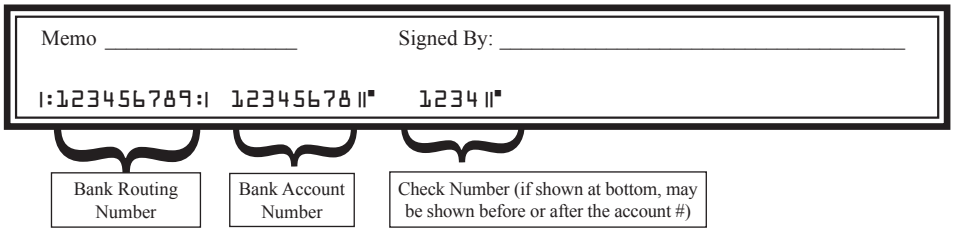
☐ Other _____

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)

Y6925

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

Companion Life Insurance Company

A Mutual *of* Omaha Company

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

Conditional Receipt

A Conditional Receipt ("Receipt") requires that the applicant submit a check for the first modal premium.

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

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

ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO COMPANION LIFE INSURANCE COMPANY ("COMPANION"). 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 amount received is sufficient to pay: (a) the first premium of a fixed premium plan, at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan.

(2) All required medical examinations 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 the underwriting standards of Companion 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.

If any of the above conditions are not met or if any proposed insured dies by suicide, the liability of Companion 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 $100,000 and shall also not exceed the death benefit applied for. If Companion 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's liability will be limited to the return of the premium paid. Companion 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 that have been fully explained to me by the producer.

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)

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Companion Life Insurance Company

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

I authorize Mutual of Omaha Insurance Company and their affiliated companies (Mutual), or authorized third party vendor, to disclose personal and medical information about me to my insurance agent and/or agency.

Information that Mutual or an authorized third party vendor may disclose includes medical information and other personal information as it relates to actions Mutual may have taken based on this information, such as charging me a higher premium for my insurance, changing benefits to something other than I applied for or declining my application for insurance.

The information will be used to help me with the insurance application process or to find other insurance coverage options.

I understand that if the person or entity that receives the above information is not covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may refuse to sign this authorization. If I refuse to sign it will not affect the issuance of the insurance for which I am applying.

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to: Mutual of Omaha, ATTN: Individual Underwriting, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

I realize that my right to revoke this authorization is limited to the extent that Mutual has taken action in reliance on the authorization.

I understand that I will receive a copy of the authorization.

X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

M28704

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and notifications on the following pages are to be left with applicant(s).

Companion Life Insurance Company

A Mutual *of* Omaha Company

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

Conditional Receipt

A Conditional Receipt ("Receipt") requires that the applicant submit a check for the first modal premium.

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

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

ALL CHECKS FOR PREMIUMS MUST BE MADE PAYABLE TO COMPANION LIFE INSURANCE COMPANY ("COMPANION"). 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 amount received is sufficient to pay: (a) the first premium of a fixed premium plan, at the mode applied for; or (b) the first planned periodic premium on a flexible premium plan.

(2) All required medical examinations 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 the underwriting standards of Companion 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.

If any of the above conditions are not met or if any proposed insured dies by suicide, the liability of Companion 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 $100,000 and shall also not exceed the death benefit applied for. If Companion 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's liability will be limited to the return of the premium paid. Companion 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 that have been fully explained to me by the producer.

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 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, Inc. 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, Inc. Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc. 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, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'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, Inc. may be obtained on its website at www.mib.com.

Y6835

GIVE THIS COPY TO THE APPLICANT

Companion Life Insurance Company

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

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.

GIVE THIS COPY TO THE APPLICANT Y6837

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

Applicant's Copy

Mutual of Omaha Insurance Company
United of Omaha Life Insurance Company
Companion Life Insurance Company

Authorization for Release of Information to My Insurance Agent, Agency and/or Authorized Third Party Vendor

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X _____ Signature of Applicant A	_____ Date
X _____ Signature of Applicant B	_____ Date

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