

APPLICATION FOR INSURANCE TO:
(Please Print)



UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777, MERIDIAN, IDAHO 83680-7777

1. Proposed Insured		Email _____		Mail Policy to:		<input type="checkbox"/> Male	
		Phone () _____		<input type="checkbox"/> Client <input type="checkbox"/> Agent		<input type="checkbox"/> Female	
2. Birthdate	Age Last Birthday	State of Birth	Social Security #	Height ft. in.	Weight lbs.		
3. Residence		Street	City	State	Zip		
4. Primary Beneficiary		Relationship	Address				
5. Contingent Beneficiary		Relationship	Address				
6. Owner - Who shall be owner of policy issued?		<input type="checkbox"/> Proposed Insured		<input type="checkbox"/> Other: Relationship _____			
Other: Name & Address				Other: Social Security # _____			
7. Do you have any existing life or annuity insurance coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes list company and address			
8. Plan:		Face Amount	Amount Paid	Premium Mode		<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly P.C.	
<input type="checkbox"/> Protector Whole Life				<input type="checkbox"/> Graded Benefit		Automatic Premium Loan <input type="checkbox"/> Yes <input type="checkbox"/> No	
8a. Accidental Death Rider		<input type="checkbox"/> Yes \$ _____		Physicians Name, Address, and Telephone Number			
8b. Accelerated Benefit Rider		<input type="checkbox"/> Yes (ABR will only be issued if required ABR disclosure accompanies application.)					

9. Has the proposed insured had or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
10. Within the past 12 months has the proposed insured:		
a) had a brain tumor, stroke, heart attack, congestive heart failure, or kidney insufficiency?	<input type="checkbox"/>	<input type="checkbox"/>
b) had surgery or been advised to have surgery to the heart or blood vessels, angioplasty, a pacemaker installed, or used or been advised to use oxygen to assist breathing?	<input type="checkbox"/>	<input type="checkbox"/>
c) had or received treatment for internal cancer, melanoma, leukemia or had more than one occurrence of cancer in their lifetime?	<input type="checkbox"/>	<input type="checkbox"/>
d) been admitted to or confined in a hospital two or more times?	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past 24 months (5 years for liver and lung transplants) has the proposed insured had or been advised to have:		
a) an organ transplant, kidney dialysis, or amputation due to disease;	<input type="checkbox"/>	<input type="checkbox"/>
b) treatment for Alzheimer's disease, dementia, Huntington's disease, Duchenne's muscular dystrophy, or ALS (Lou Gehrig's disease);	<input type="checkbox"/>	<input type="checkbox"/>
c) treatment for liver cirrhosis, drug or alcohol abuse, or been advised by a medical professional to reduce the consumption of alcoholic beverages due to excessive use?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you currently bedridden at home, confined to a nursing home, long term care facility, or receiving hospice or home health care?	<input type="checkbox"/>	<input type="checkbox"/>

If answers to the above are correctly answered "No", the proposed insured will qualify for a Protector Graded Benefit Policy.*

13. In the past 24 months has the proposed insured had, been diagnosed as having, advised to or received treatment (including medications) from a medical professional for:		
a) angina pectoris (chest pain), stroke, heart attack, or any other heart or circulatory disease or disorder (except for high blood pressure under control by medication)?	<input type="checkbox"/>	<input type="checkbox"/>
b) internal cancer, melanoma, leukemia, emphysema, tuberculosis, chronic obstructive pulmonary (lung) disease, kidney insufficiency, chronic digestive disease, or liver disorder?	<input type="checkbox"/>	<input type="checkbox"/>
14. Has the proposed insured been diagnosed as having:		
a) diabetes at or before age 40 or diabetes requiring more than 60 units of insulin per day?	<input type="checkbox"/>	<input type="checkbox"/>
b) Down's syndrome, or if under age 21; cystic fibrosis, birth defects, or muscular disease?	<input type="checkbox"/>	<input type="checkbox"/>
c) within the last 12 months, a disability caused by muscular dystrophy, lupus, multiple sclerosis, epilepsy, cerebral palsy, Parkinson's disease, or any other muscular or neurological disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d) a nervous or mental condition requiring two or more medications?	<input type="checkbox"/>	<input type="checkbox"/>
15. Please issue a Graded Benefit Life Policy at the same premium amount if a Protector Whole Life Policy is not issued	<input type="checkbox"/>	<input type="checkbox"/>
Graded Benefit: First year – 30% of face amount; Second year – 70%; thereafter 100% (proposed insured's initials)		
(Ultimate amount is paid if accidental death occurs during first two policy years.)		<input type="checkbox"/>

If answers to questions 9-15 are correctly answered "No", proposed insured will qualify for a Protector Whole Life Policy.*
(* Must also meet height and weight requirements for the plan.)

AUTHORIZATION TO DRAW CHECKS ON MY ACCOUNT AND REQUEST FOR PRE-AUTHORIZATION CHECK PLAN

To: United Heritage Life Insurance Company

Name of Policyholder

Payment Date (PLEASE CHECK ONE)

4TH

10TH

18TH

25TH

AUTHORIZATION TO HONOR CHECKS DRAWN BY UNITED HERITAGE LIFE INSURANCE COMPANY

TO: THE BANK NAMED ON THE REVERSE SIDE For my benefit and convenience, I hereby request and authorize you to pay and charge to my account any checks, drafts, orders or debit entries drawn or initiated by the UNITED HERITAGE LIFE INSURANCE COMPANY to its own order. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check, draft, order or debit entry. In consideration of your compliance with such request and authorization, I agree that your treatment of any check, draft, order or debit entry, and your rights in respect to it, shall be the same as if it were signed or initiated personally by me and that if any such check, draft, order or debit entry be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor could result in the forfeiture of insurance.

(COMPLETE REVERSE SIDE)

DATE

BANK SIGNATURE(S) OF DEPOSITOR(S)

ATTENTION: We have been authorized to withdraw premiums on pre-authorized checks payable to United Heritage Life Insurance Company. A sample check has been obtained for the purpose of correctly positioning the MICR symbols and numbers, therefore a specification sheet will not be needed. Thank you for your cooperation.

CONDITIONAL RECEIPT

Received from _____ Date _____
the sum of \$ _____ the initial premium for policy. The payment is received subject to the conditions on the other side of this receipt. This receipt does not provide any insurance. The policy shall not take effect until the policy is received by the owner and the first premium is paid in full, provided the Proposed Insured's health and other conditions are as described in the application at the time of receipt of the policy.

Signature of Agent

Signature of Owner/Applicant

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO UNITED HERITAGE LIFE INSURANCE COMPANY

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that United Heritage Life Insurance Company may make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. United Heritage Life Insurance Company may also release information in its file to its reinsurers, other insurance companies to which you may apply for life or health insurance or to its Marketing Company's designated representative where legally permissible. Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P. O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone (617) 426-3660.

In order to be eligible for:											
Protector Whole Life						Protector Graded Benefit					
Height	Weight must be at least:	But not more than:	Height	Weight must be at least:	But not more than:	Height	Weight must be at least:	But not more than:	Height	Weight must be at least:	But not more than:
4'8"	84	200	5'8"	118	282	4'8"	79	237	5'8"	106	320
9"	86	208	9"	120	290	9"	80	243	9"	109	328
10"	88	215	10"	124	300	10"	83	250	10"	112	335
11"	90	222	11"	127	310	11"	85	257	11"	115	344
5'0"	96	230	6'0"	131	321	5'0"	87	264	6'0"	118	358
1"	98	235	1"	135	330	1"	89	273	1"	121	365
2"	100	243	2"	138	337	2"	91	279	2"	124	374
3"	103	250	3"	141	345	3"	94	286	3"	127	380
4"	106	257	4"	145	350	4"	96	293	4"	130	385
5"	109	261	5"	150	360	5"	98	300	5"	134	395
6"	112	270	6"	155	370	6"	100	307	6"	138	405
7"	115	275	7"	159	380	7"	103	312	7"	142	415

OTHER INSURED SECTION - Protector Whole Life Only

Number of Units of Child Term Rider _____ .

NAME(S) OF OTHER INSURED(S)	RELATIONSHIP TO OWNER	DATE OF BIRTH	MALE OR FEMALE	HEIGHT	WEIGHT

I have read and answered questions 9 through 15 on the front of the application for the above listed proposed insured.

Remarks:

DISCLOSURE AND AUTHORIZATION TO OBTAIN INFORMATION

All statements contained in this application for insurance shall be deemed representations and not warranties. I have read the application questions and answers. I verify that they are complete and correct. I agree that this application shall form a part of any policy issued. I understand that no agent is authorized to pass on the acceptability for insurance, to modify or change any contract, or to waive any Company requirement. I agree that no waiver or change shall bind the Company unless it is in writing and signed by an officer of the Company. I agree this policy shall not take effect until the policy is received by the owner and the first premium is paid in full, provided the Proposed Insured's health and other conditions are as described in this application at the time of receipt of the policy. I authorize any physician, hospital, clinic, or other medically related facility, insurance company, the Medical Information Bureau, or other organization, or person to release to United Heritage Life Insurance Co. or its reinsurer's any and all information with reference to me or my health. A photographic copy of this authorization shall be as valid as the original, for up to 24 months from the date of this application. I have read the Notice of Disclosure of Information detached from this application and delivered to me on this date. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil fines and criminal penalties. I have paid \$ _____ for a life insurance policy.

Proposed Insured's Signature	Date	City & State Where Signed
Owner's Signature	Date	City & State Where Signed
AGENT STATEMENT: I certify that I have correctly recorded here the information furnished by the Owner and/or Insured. To the best of my knowledge replacement <input type="checkbox"/> is <input type="checkbox"/> is not involved in this transaction.		
Agent's Signature	Agent #	2nd Agent's Signature Agent #

PARTICULARS OF BANK ACCOUNT TO BE CHARGED

(TYPE OR PRINT)

Account number: _____

Name(s) on bank account: _____

TO: BANK _____

ADDRESS _____

CITY, STATE _____

IMPORTANT:

1. COMPLETE BOTH SIDES OF THIS FORM. LIST ALL POLICY NUMBERS INVOLVED.
2. SEND ENTIRE FORM TO HOME OFFICE WITH A VOIDED BLANK CHECK.
3. PLEASE TYPE OR PRINT FULL BANK ADDRESS.

This receipt is not valid unless it is signed by an agent of the Company. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment, or the authorization for payment of premiums remains in effect until the first premium is transmitted to the Company.

Except as provided in this conditional receipt, any policy issued by the Company shall not take effect until the full first premium is paid and the policy is received by the owner during the lifetime of each person to be covered by such policy, and all of the statements and answers given in the application continue to be true, complete, and accurate to the best of the Proposed Insured's knowledge and belief as of the date of receipt of the policy.

NEITHER THE AGENT NOR THE MEDICAL EXAMINER IS AUTHORIZED TO ACCEPT RISKS OR PASS UPON INSURABILITY, TO MAKE OR MODIFY CONTRACTS, OR TO WAIVE ANY OF THE COMPANY'S RIGHTS OR REQUIREMENTS.

NOTICE TO PERSONS APPLYING FOR INSURANCE

Federal law requires you to be advised that in connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation.

It is possible that a representative of a firm employed to make such reports may call upon you in person. You have the right to request disclosure of the nature and scope of the investigation upon your written request made within a reasonable time after receipt of the notice.