WHOLE LIFE

Simplified Issue Agent Guide

United American Insurance Company
Since 1947

UAI2990 **0717**

HOW TO CONTACT UNITED AMERICAN

By mail: United American Insurance Company P.O. Box 8080, McKinney, TX 75070-8080

Contact the Agent Service Center Phone at (800) 925-7355, or email at agencyservice@torchmarkcorp.com For supply requests, Fax a Supply Order Form to (469) 525-4290, email to agentsupply@torchmarkcorp.com, or

Agent information and UA General Agency Office link can be found on UAOnline at www.unitedamerican.com/logon

BEFORE YOU BEGIN

Make sure you have:

1. Agent licensing and UA Appointment procedures complete. A Writing Agent Number will be required on all forms.

2. Current Compliance Sheets listing the materials and required forms for the product portfolio approved in your state(s).

BASE PLANS

	Final Expense Whole Life			Juvenile Whole Life		
Benefits	Permanent lifetime coverage			Permanent lifetime coverage		
Issue Ages	50-80			0-18		
Issue Amounts	$1,000 - $25,000* ($5,000 - $25,000 in WA)			$1,000 - $25,000 ($5,000 - $25,000 in WA)		
Renewability	Guaranteed for life as long as premiums are paid on time			Guaranteed for life as long as premiums are paid on time		
Simplified Underwriting	- MIB - Prescription drug database - Telephone interview if needed - Height and weight chart			- MIB - Prescription drug database - Telephone interview if needed - Height and weight chart		
Premium Classes	- Male/Female Nontobacco - Male/Female Tobacco			Male/Female		
Modal Factors		Automatic Payment Plan	Direct Bill		Automatic Payment Plan	Direct Bill
	Annual	1.000	1.000	Annual	1.000	1.000
	Semi-annual	0.500	0.520	Semi-annual	0.500	0.520
	Quarterly	0.250	0.265	Quarterly	0.250	0.265
	Monthly EFT	1/12	0.090	Monthly EFT	1/12	0.090
Policy Fee	$20 Annual Fee			$20 Annual Fee		
Cash Values	Accumulates cash and loan value			Accumulates cash and loan value		

RIDER

Accelerated Benefit Rider**	
Benefit	Pays a 50% advance on base policy death benefit
Qualifying Event	Terminal condition with life expectancy of 12 months or less. Not available on graded benefit or substandard policies
Issue Ages	Same as base plans
Premiums	No additional premium charge

**Maximum face amount is limited to $150 monthly premium per insured, and $300 monthly premium per household.*
***Accelerated Benefit Rider not available in Connecticut, Massachusetts, New Jersey, Pennsylvania, South Carolina, Vermont, Washington, or West Virginia*

INSTRUCTIONS FOR COMPLETING THE JUV14 APPLICATION

REQUESTED EFFECTIVE DATE
The Effective Date of the policy is the Underwriting Date or the specific policy date requested on the application.

The Underwriting Date is the later of: (1) the date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed. A specific effective date can be requested within the following parameters:

- Backdating up to 6 months to save age is allowed.
- All premiums must be submitted with the application.

PAYMENT MODE
Check the payment mode selected. *Monthly payments are available only with Electronic Funds Transfer (bank draft)*. If the premiums will be paid by Bank Draft, indicate preferred draft date in addition to the payment mode selection.

Please note: the *initial* premium will be drafted on the day the policy is issued.

PLAN OF LIFE INSURANCE
Whole Life

BENEFIT AMOUNTS
$1,000 - $25,000 ($5,000 - $25,000 in Washington)

Indicate the **amount of insurance** (base plan only) and the amount of premium paid with the application.

The combined total of all Final Expense Whole Life (policy forms SWL/SWLGD UA plan codes FER-FES, GER-GEU) monthly premiums written in the household cannot exceed $150/month.

OWNER
Fill this out completely, being sure to include the Social Security number and phone number of the Primary Applicant (Policy Owner).

The Policy Owner must have an insurable interest in the life of each Insured. The insurable interest requirement is satisfied if the individual is an immediate family member or would suffer an economic loss by the death of the Proposed Insured. The relationship must be stated on the application.

BENEFICIARY
The beneficiary for children will be the Policy Owner. If the Owner is other than the Proposed Insured, the beneficiary must have an insurable interest. The relationship must be stated on the application.

CHILDREN COVERED IN THE POLICY
Children must be age 0-18. When calculating the Proposed Insured's age, if a specific effective date is requested or if the first premium is to be paid by bank draft, calculate the age as of the effective date or draft date, not the application date.

The Life Face Amount can be different for each child.

ELIGIBILITY
Refer to the Juvenile Build Chart in this manual.

Weight exceeding the maximum will be declined.

Answer the questions for each Child to be covered under the policy. Applicants with 'YES' answers to questions 5-7 on the JUV14 application are not eligible for coverage.

Applicants with health conditions listed as unacceptable risks are not eligible for coverage.

Any Applicant or Owner who has had a Life policy lapse in the last 12 months is not eligible for coverage.

REPLACEMENT
Be sure to comply with all Replacement Regulation requirements for your state if the policy is intended to replace an existing policy.

A replacement should be recommended only when it is in the best interest of the Applicant. Any time that you complete a replacement notice, you must submit a copy with the application and leave a copy with the Applicant.

Replacement of existing Torchmark Corporation subsidiary policies is not allowed. Torchmark subsidiaries include: American Income Life Insurance Company, Family Heritage Life Insurance Company of America, First United American Life Insurance Company, Globe Life And Accident Insurance Company, Liberty National Life Insurance Company, National Income Life Insurance Company, and United American Insurance Company.

SIGNATURES
The Policy Owner must sign the application. Signatures are to be witnessed by the Agent.

Note: The application must be received by the Company within 30 days of signature.

BANK DRAFT AUTHORIZATION
Complete the Bank Draft section if the initial premium and/or subsequent premiums are to be paid by EFT. Select a draft day if *subsequent* premiums are to be paid by monthly EFT on a specified date.

Please note: the *initial* premium will be drafted on the day the policy is issued.

Helpful information for Social Security recipients:

Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1st – 10th	14th
Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

Drafts cannot be the 29th, 30th, or 31st.

SEND POLICY TO:
Check the appropriate box at the bottom of the application to indicate whether the policy will be mailed to the Agent or to the Policy Owner. If neither box is checked, the policy will be mailed to the Policy Owner.

APPLICATION FOR LIFE INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO. * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

Requested Effective Date (mm-dd-yyyy) 09 / 21 / 2014 — 20

Payment Mode ○ Monthly ○ Semi-Annual ○ Quarterly ○ Annually

Payment Type ● Bank Draft ○ Direct

Draft Day (01 to 28 only) 15

LIFE PLAN

		Life Face Amount	Premium
● **Child 1**	● **Whole Life**	$ 10,000	$ 4.30
● **Child 2**	● **Whole Life**	$ 10,000	$ 2.80
○ **Child 3**	○ **Whole Life**	$	$
○ **Child 4**	○ **Whole Life**	$	$
○ **Child 5**	○ **Whole Life**	$	$

Total Premium $ 7.10

Total Collected with Application $

Applicant if other than Owner

Name: _____ Relationship to Owner: _____

Address: _____ City: _____ State: _____ ZIP: _____

Best time to call:
● 8 AM - Noon
○ Noon - 6 PM
○ 6 PM - 9 PM

Home Phone No. 555 444 3333

Work Phone No. 222 111 0000

APPLICATION FOR LIFE INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO. * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

Owner of Children's Insurance

First Name: ANY M.I.: O
Last Name: PERSON ● Male ○ Female
Address: 101 ANYWHERE
City: SOMEPLACE State: TX Zip Code: 75757 Age: 45
Birth State: TX Date of Birth (mm-dd-yyyy): 02-01-1970 SS #: 999-99-9999
E-mail Address: APERSON@WHAT.NET
Relationship of Owner to Children: FATHER

Beneficiary for Children will be Owner (*unless notice is given to United American Insurance Company's Home Office).*

Child 1
First Name: JOHN M.I.: A ● Male ○ Female Height (ft. in.): 42 Weight (lbs.): 40
Last Name: PERSON
Age: 06 Date of Birth (mm-dd-yyyy): 03-01-2008 SS #: 111-11-1111

Child 2
First Name: JANE M.I.: B ○ Male ● Female Height (ft. in.): 30 Weight (lbs.): 25
Last Name: PERSON
Age: 03 Date of Birth (mm-dd-yyyy): 01-01-2011 SS #: 222-22-2222

Child 3
First Name: M.I.: ○ Male ○ Female Height (ft. in.): Weight (lbs.):
Last Name:
Age: Date of Birth (mm-dd-yyyy): - - SS #: - -

Child 4
First Name: M.I.: ○ Male ○ Female Height (ft. in.): Weight (lbs.):
Last Name:
Age: Date of Birth (mm-dd-yyyy): - - SS #: - -

Child 5
First Name: M.I.: ○ Male ○ Female Height (ft. in.): Weight (lbs.):
Last Name:
Age: Date of Birth (mm-dd-yyyy): - - SS #: - -

ALL LIFE INSURANCE APPLICANTS MUST ANSWER ALL THE FOLLOWING QUESTIONS.	CHILD 1 **YES/NO**	CHILD 2 **YES/NO**	CHILD 3 **YES/NO**	CHILD 4 **YES/NO**	CHILD 5 **YES/NO**
1. Are all Children proposed to be Insured permanent residents of the United States or Canada?	●○	●○	○○	○○	○○
2. Do you have complete knowledge of the health information of all Children proposed to be Insured?	●○	●○	○○	○○	○○
3. Do any Children proposed to be Insured have existing (or pending applications for) life insurance or annuity contracts in force? If yes, list coverage type _____	○●	○●	○○	○○	○○
4. Will the life insurance being applied for replace or change any existing life insurance? (If "Yes," complete a Replacement Form).	○●	○●	○○	○○	○○
IF THE ANSWER IS "YES" TO ANY ONE OF QUESTIONS 5-7 BELOW FOR ANY CHILD, THEN THAT CHILD IS NOT ELIGIBLE FOR COVERAGE.					
5. Has any Child proposed to be Insured in the past **12 MONTHS,**					
a. been administered oxygen or confined for 24 hours or more to a hospital, neonatal ICU, or psychiatric facility excluding confinements for: normal childbirth, normal neonatal care, and conditions for which the proposed insured has completely recovered?	○●	○●	○○	○○	○○
b. been advised by a medical professional to have a diagnostic test (excluding HIV and AIDS) or surgery that has not been performed or for which results have not been received?	○●	○●	○○	○○	○○
c. had uncontrolled epilepsy or more than 2 seizures for any reason?	○●	○●	○○	○○	○○
d. been convicted of operating a vehicle while under the influence of drugs or alcohol, been convicted of reckless driving, or had a suspended or revoked driver's license?	○●	○●	○○	○○	○○
6. Has any Child proposed to be Insured in the past **10 YEARS** been diagnosed with, treated for, or taken prescription drugs for any of the following:					
a. Cancer in any form including leukemia, lymphoma, osteosarcoma, and Hodgkin's disease?	○●	○●	○○	○○	○○
b. Heart disease, heart surgery, stroke, transient ischemic attack (TIA), mini-stroke, or uncontrolled high blood pressure?	○●	○●	○○	○○	○○
c. Multiple sclerosis, muscular dystrophy, or systemic lupus?	○●	○●	○○	○○	○○
d. Kidney disease, liver disease, chronic hepatitis, hepatitis C, insulin dependent diabetes, or sickle cell anemia?	○●	○●	○○	○○	○○
e. Depression, bipolar disorder, alcohol or drug abuse, spina bifida, or any surgery or injury to the brain or spinal cord from which the Child has not fully recovered?	○●	○●	○○	○○	○○
7. Has any Child proposed to be Insured **EVER,**					
a. been diagnosed with any immune deficiency including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?	○●	○●	○○	○○	○○
b. had or been advised by a medical professional to have an organ or tissue transplant; of having any illness indicated as being terminal; or of having a life expectancy of 10 years or less?	○●	○●	○○	○○	○○
c. been diagnosed with Down Syndrome or a Chromosomal Disorder?	○●	○●	○○	○○	○○

APPLICATION FOR LIFE INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO. * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

AGREEMENT: I hereby apply to United American Insurance Company for a policy to be issued solely and entirely in reliance upon the written answers to the foregoing questions, and I expressly agree on behalf of myself and any person who shall claim any interest in any policy issued on this application as follows: (1) All statements and answers contained herein are full, complete and true to the best of my knowledge and belief. (2) The insurance hereby applied for shall not be considered in force until a policy is issued and delivered to me and the full first premium paid thereon while the Proposed Insured's health and other conditions remain as described in this application.

I HEREBY AUTHORIZE the MIB, Inc., any insurance company, hospital, physician, or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that I or an authorized representative may request a copy of this authorization. Information for consumers MIB , Inc. may be obtained on its website at www.mib.com.

Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

To the best of your knowledge as writing agent, is the insurance applied for intended to replace any existing insurance? ○ **Yes** ● **No**

I certify I have personally seen the applicant/child(ren). ● **Yes** ○ **No**

I certify that I have accurately recorded the information supplied by the applicant.

Best Agent

Agent's Signature

Last Name AGENT Agent No. 010101

Print First 5 Letters of Agent's Last Name

SEND POLICY TO: ● Agent ○ Insured

(The Policy will be sent to Insured unless otherwise instructed.)

Date Application Signed (mm-dd-yyyy) 09 - 01 - 2014

SOMEPLACE TX

City State

Signed Any Person

Owner

Signed

Applicant (If other than the Owner)

Signed

Child's Signature (If over the age of 18)

Signed

Child's Signature (If over the age of 18)

JUV14

United American Insurance Company
Since 1947

Bank Draft Authorization

Draft date cannot be the 29th, 30th or 31st.

Proposed Insured's Social Security Number

999 - 99 - 9999

Requested Bank Draft Day (dd)

15

Payor's First Name

ANY

M.I.

Payor's Last Name

PERSON

Bank ABA Routing Number

012345678

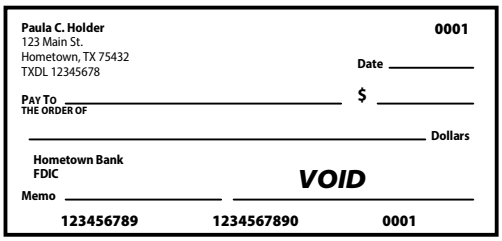
Account Number

1112223334445 5

Bank Name

SOMEPLACE NATIONAL

Account information fields above must be complete if voided check is not attached.
See the example check below for the location of the Bank Routing Number and Account Number.



Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1st – 10th	14th
Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

As a convenience to me, I hereby request and authorize you, United American Insurance Company, McKinney, Texas, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

NOTE - <u>Business</u> accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (SP 9-01) are required.

Amy Person

Payor's Signature (as it appears on bank records)

FORM 1080-C

48656

UAI1756 **0615**

INSTRUCTIONS FOR COMPLETING THE UL14 APPLICATION

REQUESTED EFFECTIVE DATE

The Effective Date of the policy is the Underwriting Date or the specific policy date requested on the application.

The Underwriting Date is the later of: (1) the date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed. A specific effective date can be requested within the following parameters:

- Backdating up to 6 months to save age is allowed.
- All premiums must be submitted with the application.

PAYMENT MODE

Check the payment mode selected. *Monthly payments are available only with Electronic Funds Transfer (bank draft)*. If the monthly payments will be paid by Bank Draft, indicate preferred draft date in addition to the payment mode selection.

Please note: the *initial* premium will be drafted on the day the policy is issued.

PLAN OF LIFE INSURANCE

Whole Life

BENEFIT AMOUNTS

$1,000 - $25,000 ($5,000 - $25,000 in Washington)

Indicate the **amount of insurance** (base plan only) and the amount of premium paid with the application.

The combined total of all Final Expense Whole Life (*policy forms SWL/SWLGD, UA plan codes FER-FES, GER-GES, GET-GEU*) monthly bank draft premiums written in the household cannot exceed $150 per insured and/or $300 per household. (Note: The juvenile product does not have the household limit.)

PRIMARY APPLICANT

Fill this out completely, being sure to include the Social Security number and phone number of the Primary Applicant. When calculating the Proposed Insured's age, if a specific effective date is requested or if the first premium is to be paid by bank draft, calculate the age as of the effective date or draft date, not the application date.

BENEFICIARY

If the Proposed Applicant is the Owner, he or she may name the beneficiary of their choice. If the Owner is other than the Proposed Insured, the beneficiary must have an insurable interest. The relationship must be stated on the application.

GRADED DEATH BENEFIT

Graded Death Benefit is for applicants with certain health conditions that may otherwise be considered uninsurable.
Sub-Standard in lieu of Graded Benefit policies in MA, MN, NJ, NC, NH, SC, TX, WA or WV.

1st Policy Year	2nd Policy Year	3rd Policy Year	4th Policy Year+
25% of the benefit	50% of the benefit	75% of the benefit	100% of the benefit

Example: One unit is defined as $250 in policy year one, $500 in policy year two, $750 in policy year three, and $1,000 in policy year four and above. For accidental death during the first three policy years, $1,000 death benefit is paid per unit of insurance

ELIGIBILITY

Refer to the Unisex Build Chart this in manual.

Weight exceeding the maximum will be declined.

Answer the questions for each Applicant to be covered under the policy. Applicants with 'YES' answers to questions 1-5 on the UL14 application are not eligible for coverage.

Graded (sub-standard) Benefit policies are available to Applicants with Yes answers to questions 6 & 7.

Applicants with health conditions listed as unacceptable risks are not eligible for coverage.

Any Applicant or Owner who has had a Life policy lapse in the last 12 months is not eligible for coverage.

REPLACEMENT

Answer replacement question 10 on Final Expense Application. Be sure to comply with all Replacement Regulation requirements for your state if the policy is intended to replace an existing policy.

If the Applicant *does not have* any existing life insurance or annuities, your duties with respect to replacement are complete.

Replacement of existing Torchmark Corporation subsidiary policies is not allowed. Torchmark subsidiaries include: American Income Life Insurance Company, Family Heritage Life Insurance Company of America, First United American Life Insurance Company, Globe Life And Accident Insurance Company, Liberty National Life Insurance Company, National Income Life Insurance Company, and United American Insurance Company.

SIGNATURES

The Proposed Insured must sign the application. If the Owner will be other than the Insured, the Owner must sign as well. Signatures are to be witnessed by the Agent.

Note: The application must be received by the Company within 30 days of signature.

SEND POLICY TO:

Check the appropriate box at the bottom of the application to indicate whether the policy will be mailed to the Agent or to the Policy Owner. If neither box is checked, the policy will be mailed to the Policy Owner.

BANK DRAFT AUTHORIZATION

Complete the Bank Draft section if the initial premium and/or subsequent premiums are to be paid by EFT. Select a draft day if *subsequent* premiums are to be paid by monthly EFT on a specified date.

Please note: the *initial* premium will be drafted on the day the policy is issued.

Helpful information for Social Security recipients:

Social Security Benefits Paid On	Birth Date On	Draft Date
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Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

Drafts cannot be the 29th, 30th, or 31st.

APPLICATION FOR LIFE INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO. * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

Requested Effective Date (mm-dd-yyyy) 09-21-20__

Payment Mode ○ Monthly ○ Semi-Annual ○ Quarterly ○ Annually

Payment Type ● Bank Draft ○ Direct

Draft Day (01 to 28 only) 15

LIFE PLAN

		Life Face Amount	Premium
● **Primary Applicant**	● **Whole Life**	$ 25,000	$ 80.03
● **Spouse**	● **Whole Life**	$ 25,000	$ 60.56

Total Premium $ 140.59

Total Collected with Application $ _____

Applicant if other than Primary Applicant/Owner

Name: _____ Relationship to Primary Applicant: _____

Address: _____ City: _____ State: _____ ZIP: _____

Is Primary Applicant to be Owner of all Policies? If "No", Owner shall be Primary Applicant. ○ **Yes** ○ **No**

Best time to call:
○ 8 AM - Noon
● Noon - 6 PM
○ 6 PM - 9 PM

Home Phone No. 111-222-3333

Work Phone No. 444-556-6666

APPLICATION FOR LIFE INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO. * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

Primary Applicant

First Name: JOHN | M.I.: A | Height (ft. in.): 7 2

Last Name: PERSON | ● Male ○ Female | Weight (lbs.): 180

Address: 1212 QUIET STREET

City: SMALL TOWN | State: TX | Zip Code: | Age:

Birth State: TX | Date of Birth (mm-dd-yyyy): 06-01-1949 | SS #: 888-88-8888

E-mail Address: JAPERSON@WHAT.NET

I, the agent, have personally seen this person. ● **Yes** ○ **No**

Primary Applicant's Occupation: LAWYER

Primary Applicant's Beneficiary: JANE PERSON | Beneficiary Relationship: SPOUSE

Beneficiary for Spouse will be Primary Applicant(owner) *unless notice is given to United American Insurance Company's Home Office.*

Spouse First Name: JANE | M.I.: B | Height (ft. in.): 5 9

Last Name: PERSON | ○ Male ● Female | Weight (lbs.): 140

Age: 65 | Birth State: TX | Date of Birth (mm-dd-yyyy): 05-25-1949 | I, the agent, have personally seen this person. ● **Yes** ○ **No**

Occupation: DOCTOR

IF THE ANSWER IS "YES" TO ANY ONE OF QUESTIONS 1-5 BELOW FOR THE PRIMARY APPLICANT AND/OR SPOUSE, THEN THE PRIMARY APPLICANT AND/OR SPOUSE IS NOT ELIGIBLE FOR COVERAGE.	PRIMARY APPLICANT **YES/NO**	SPOUSE **YES/NO**
1. Has the Applicant ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or had test results indicating exposure to the Human Immunodeficiency Virus (HIV)?	○●	○●
2. Is the Applicant bedridden, hospitalized, a resident of a nursing facility or require assistance with activities of daily living (eating, bathing, dressing, etc.)?	○●	○●
3. Has any Applicant:		
a. Been advised that they have a terminal illness?	○●	○●
b. Had amputation due to illness or disease?	○●	○●
c. Been advised to have or had an organ (other than cornea) or bone marrow transplant?	○●	○●
d. Been diagnosed or treated for cirrhosis or Amyotrophic Lateral Sclerosis (ALS)?	○●	○●
e. Been diagnosed as having or received treatment for chronic kidney failure, which includes dialysis?	○●	○●
f. Been diagnosed, treated, or advised to treat, or ever taken medication for: Chronic kidney disease or disorder, Alzheimer's disease, Dementia, Muscular dystrophy or atrophy, Parkinson's disease, Multiple sclerosis, Cerebral palsy, Sickle cell anemia, Cystic fibrosis, Down syndrome, Systemic lupus (SLE), or Huntington's disease?	○●	○●
g. Had a cardiac defibrillator implanted?	○●	○●
4. Within the ***past year***, has the Applicant been advised to be or been hospitalized for a heart or circulatory condition including stroke, heart attack, congestive heart failure or heart valve disorder?	○●	○●
5. Within the ***past two (2) years***, has the Applicant:		
a. Been diagnosed as having, received treatment for, or been advised to take tests to determine if they have cancer (other than skin), leukemia, lymphoma, melanoma, sarcoma or other malignant tumor or growth?	○●	○●
b. Had Chronic Lung Disease which requires oxygen equipment to assist in breathing?	○●	○●
c. Been diagnosed or received treatment for drug or alcohol abuse or been advised by a physician to reduce drug or alcohol consumption?	○●	○●

IF THE PRIMARY APPLICANT OR SPOUSE ANSWERS "NO" TO QUESTIONS 1-5, BUT THEN ANSWERS ANY OF THE FOLLOWING QUESTIONS 6-7 "YES," THE PRIMARY APPLICANT OR SPOUSE MAY ONLY BE ELIGIBLE FOR A GRADED DEATH BENEFIT LIFE PLAN. IF THE PRIMARY APPLICANT OR SPOUSE ANSWERS MORE THAN ONE (1) QUESTION YES, THEY MAY NOT BE ELIGIBLE FOR COVERAGE. GRADED DEATH NOT AVAILABLE FOR ALL PLANS.

6. Within the ***past three (3) years***, has any Applicant:		
a. Used a wheelchair on a daily basis in the home due to illness?	○●	○●
b. Had or received treatment for any disease or disorder of the liver (including hepatitis C) or hemophilia or lupus?	○●	○●
c. Had or been treated for mental disorder (including mental retardation) or any brain disease or disorder?	○○	○○
d. Had or been treated for chronic obstructive pulmonary disease (COPD), emphysema, or any chronic disease or disorder of the lungs?	○●	○●
e. Had diabetes that required treatment with insulin?	○●	○●
f. Had or been treated for seizure disorder or epilepsy?	○●	○●
g. Been confined to a hospital three (3) or more times?	○●	○●
h. Had or been treated for a disease or disorder of the heart, arteries, or circulatory system including stroke, heart attack, congestive heart failure, peripheral vascular disease or heart valve disorder?	○●	○●
i. Been advised by a physician to have medical or diagnostic tests to determine if they have a disease or disorder of the arteries, heart or circulatory system, but have not yet completed those tests?	○●	○●
7. During the ***past ten (10) years***, has the Applicant been diagnosed as having, received treatment for, or been advised to take tests to determine if he/she has cancer (other than skin), leukemia, lymphoma, melanoma, sarcoma or other malignant tumor or growth?	○○	○○

ALL LIFE INSURANCE APPLICANTS MUST ANSWER ALL THE FOLLOWING QUESTIONS.

8. Has any Applicant used tobacco or nicotine in any form within the past 12 months?	○●	○●
9. Does any Applicant have any existing life insurance or any pending application for life insurance? If yes, list coverage type _____	○●	○●
10. Will the life insurance being applied for replace or change any existing life insurance?	○●	○●

APPLICATION FOR LIFE INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO. * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

AGREEMENT: I hereby apply to United American Insurance Company for a policy to be issued solely and entirely in reliance upon the written answers to the foregoing questions, and I expressly agree on behalf of myself and any person who shall claim any interest in any policy issued on this application as follows: (1) All statements and answers contained herein are full, complete and true to the best of my knowledge and belief. (2) The insurance hereby applied for shall not be considered in force until a policy is issued and delivered to me and the full first premium paid thereon while the Proposed Insured's health and other conditions remain as described in this application. (3) I fully understand that if the Company should issue a graded death benefit, the death benefit payable during the first three years shall be a percentage of the initial face amount of insurance as follows: 25% first policy year, 50% second policy year, 75% third policy year and 100% the fourth policy year and thereafter. If death is a result of an accident, then the percentage reduction listed shall not apply.

In order to evaluate my application for insurance, I, HEREBY AUTHORIZE the MIB, Inc., if it has any records of my health, and any pharmacy or pharmacy benefits manager that possesses prescription history about me to give any and all such information to the United American Insurance Company. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for 30 months from the date signed and may be revoked by sending written notice to United American Insurance Company. I acknowledge receipt of the MIB, Inc. Pre-Notice. A photographic copy of this authorization will be as valid as the original. I am or the person authorized to act on my behalf is entitled to receive a copy of this authorization form. Information for consumers MIB, Inc. may be obtained on its website at www.mib.com.

Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

To the best of your knowledge as writing agent, is the insurance applied for intended to replace any existing insurance? ○ **Yes** ● **No**

I certify I have personally seen the applicant and accurately recorded the information supplied by the applicant. ● **Yes** ○ **No**

Best Agent
Agent's Signature

Last Name AGENT Agent No. 010101
Print First 5 Letters of Agent's Last Name

SEND POLICY TO: ● Agent ○ Applicant
(The Policy will be sent to Applicant unless otherwise instructed.)

Date Application Signed (mm-dd-yyyy) 09 - 01 - 2014

SMALL TOWN TX
City State

Signed John Person
Primary Applicant

Signed
Applicant (If other than the Primary Applicant)

Signed Jane Person
Spouse

UL14

"Automatic" Payment Plan / Bank Draft

Please **TAPE** personalized **VOIDED CHECK** here.
DO NOT STAPLE

"AUTOMATIC" PAYMENT PLAN / BANK DRAFT AUTHORIZATION: I authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of United American Insurance Company. This authorization is to remain in effect until revoked by me. All premiums and non-insurance charges may be automatically withdrawn from my account on **MONTHLY** mode, *unless a different mode has been selected on the application.*

John Person
Account Holder's Signature (as it appears on financial institution records)

UNACCEPTABLE RISKS

- **AIDS/ARC/HIV:** Has been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (Symptomatic or Asymptomatic) or been treated for AIDS, ARC or HIV by a physician or healthcare provider.
- **ALCOHOL:**
  - If in the past 2 years the proposed insured has been advised to stop alcohol use or received treatment and the proposed insured is still drinking alcohol.
- **ALZHEIMER'S DISEASE/DEMENTIA:** In the past 10 years, received diagnosis of or required follow-up.
- **ASTHMA:** If oxygen is required.
- **BEDRIDDEN:** Currently bedridden or confined to any hospital, nursing home, or other medical facility.
- **CANCER:**
  - If cancer has spread to the regional lymph nodes or adjacent structure or if there is any metastasis
  - Hodgkin's disease, leukemia, lymphoma, liver, lung or pancreatic cancer
  - If it has been less than 2 years since cancer treatment
  - Carcinoma in situ and cancer that is confined to the tissue or organ of origin may be considered five years after diagnosis or treatment, but medical records may be required to help in the determination of acceptable risk.
- **CORONARY ARTERY/HEART DISEASE/HEART ATTACK/ HEART SURGERY:** In the past 3 years, received diagnosis of or required follow-up for aneurysm, angina, heart arrhythmia, cardiomyopathy, congenital heart disease, congestive heart failure, coronary angioplasty (PTCA), coronary bypass surgery (CABG), heart attack, heart valve replacement, valve disorder, pacemaker, or defibrillator. Heart disease diagnosed or treated more than 10 years ago may be considered, but additional information may be required to help in the determination of acceptable risk.
- **CVA (Stroke) & TIA (Transient Ischemic Attack) (Mini Stroke):**
  - All cases less than 1 year from date of event;
  - If less than 40 at age of event;
  - All ages with moderate to severe residuals.
- **DEGENERATIVE MUSCLE or NERVE DISEASE/DISORDER**
- **DIABETES – TYPE I (Insulin):**
  - Any complications such as neuropathy (circulation), retinopathy (eye), nephropathy (kidneys), insulin shock, coma, skin ulcers, amputation, or poorly controlled diabetes;
  - Any combination of diabetes with tobacco use (use of any tobacco or nicotine product), coronary artery disease or ratable build.
- **DIABETES –TYPE II:**
  - Any complications such as neuropathy (circulation), retinopathy (eye), nephropathy (kidneys), insulin shock, coma, skin ulcers, amputation, or poorly controlled diabetes;
  - Any combination of diabetes with coronary artery disease or ratable build;
  - Tobacco use (use of any tobacco or nicotine product) in combination with diabetes for ages 50 and under.
- **DISEASE OF BRAIN / PERIPHERAL ARTERIES / LIVER / PANCREAS / KIDNEY**
- **DRUGS:** In the past 2 years, used or been treated for amphetamines, cocaine, narcotics, hallucinogens, or barbiturates.
- **EMPHYSEMA/COPD:** If moderate to severe, if a smoker or with complications.
- **IMMUNE SYSTEM or CONNECTIVE TISSUE DISEASE/ DISORDER**
- **MULTIPLE SCLEROSIS:** Received diagnosis of or required follow-up; progressive or relapsing.
- **PARALYSIS:** Any paraplegia or quadriplegia.
- **PARKINSON'S DISEASE:** Moderate, severe, or progressive.
- **SARCOIDOSIS:** In the past 2 years, received diagnosis of or required follow-up for pulmonary sarcoidosis.
- **SICKLE CELL ANEMIA**
- **SYSTEMIC LUPUS**
- **TRANSPLANT:** Has received or been recommended for an organ or bone marrow transplant.
- **TRANSPORTATION ASSISTANCE:** Permanent usage of the following: walker, wheelchair, electric scooter, oxygen, or catheter.

The above list is intended as a guide.

HEIGHT AND WEIGHT GUIDELINES

Weight is only one factor in the underwriting assessment. A build that is within the parameters does not guarantee acceptance. Weight exceeding the maximum will be declined.

UNISEX			
Height		Total Inches	Max Graded
Feet	Inches		
4′	10″	58″	199
4′	11″	59″	205
5′	0″	60″	213
5′	1″	61″	220
5′	2″	62″	227
5′	3″	63″	234
5′	4″	64″	242
5′	5″	65″	249
5′	6″	66″	257
5′	7″	67″	265
5′	8″	68″	273
5′	9″	69″	281
5′	10″	70″	289
5′	11″	71″	298
6′	0″	72″	306
6′	1″	73″	315
6′	2″	74″	323
6′	3″	75″	332
6′	4″	76″	341

JUVENILE BUILD CHART

NOTE: Refer to Adult chart if 5′6″ (66″) or above.

STANDARD		
Age - Months	Inches	Pounds
0	18 - 21	6 - 10
1	19 - 22	6 - 11
2	20 - 24	8 - 13
3	21 - 25	9 - 15
4	22 - 26	10 - 17
5	23 - 27	11 - 19
6	24 - 28	13 - 20
7	24 - 29	13 - 22
8	25 - 29	14 - 23
9	25 - 30	15 - 24
10	26 - 30	16 - 25
11	26 - 31	17 - 26
12	27 - 31	17 - 27
13	27 - 32	18 - 28
14	28 - 32	18 - 28
15	28 - 33	19 - 29
16	29 - 33	19 - 30
17	29 - 34	20 - 30
18	29 - 34	20 - 31
19	30 - 35	21 - 31
20	30 - 35	21 - 32
21	30 - 35	21 - 32
22	31 - 36	22 - 32
23	31 - 36	22 - 33
Age - Years		
2	31 - 36	22 - 33
3	34 - 40	25 - 38
4	37 - 43	29 - 44
5	39 - 46	32 - 52
6	42 - 49	36 - 60
7	44 - 51	40 - 68
8	47 - 54	44 - 79
9	48 - 57	49 - 91
10	50 - 59	54 - 105
11	52 - 61	60 - 120
12	54 - 65	67 - 134
13	54 - 65	67 - 134
14	54 - 65	67 - 134
15	54 - 65	67 - 134

SUBMITTING APPLICATIONS

MAIL PAPER APPLICATIONS

United American Insurance Company
Attn: New Business
P.O. Box 8080 McKinney, TX 75070

FAX APPLICATIONS

All applications must be written using **BLACK INK**. Each individual application, and all required supplemental forms, must be faxed as one complete document set. Only send one application per fax. Each fax should include a fax cover sheet indicating the number of pages being faxed. Faxes should be sent to 972-767-4462. If faxing in an application, do not also mail the application.

IGO E-APP® SUBMISSION

- Send electronically from iPad, laptop, or PC.
- Certification required to use.
- Accessed through UAOnline.
- Details on General Agency Office Website "e-App" tab.
- Do not take a check for initial premium or deposit.

BANKING REQUIREMENT FOR ADVANCED COMMISSIONS

Commissions on Final Expense (UL14) and Juvenile Whole Life (JUV14) applications **submitted via fax or mail** will be paid to the Writing Agent on an as earned basis unless the following bank information is provided with the application: a voided check, bank statement, or letter from customer's bank. Agents who are eligible for and have requested advances on commissions must provide one of the above required bank account verification documents with their faxed or mailed applications in order to receive advanced commissions on these policies.

Commissions on Final Expense (UL14) and Juvenile Whole Life (JUV14) applications **submitted via iGO e-App®** will be paid to the Writing Agent on an as earned basis only. No advances will be paid when submitted via iGO e-App®. Faxing in banking information separately from the iGO e-App® will **not** result in advances being paid for that policy.

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UA
United American
Insurance Company
Since 1947