

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



NEW YORK – APPLICATION FOR LIFE INSURANCE

FULLY UNDERWRITTEN PRODUCTS – ONE BASE POLICY PER APPLICATION

CHECKLIST FOR SUBMITTING A COMPLETE APPLICATION

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

PLEASE USE THE PRECISE PRODUCT AND PLAN ON THE APPLICATION TO AVOID APP AMENDS

<input type="checkbox"/> UNIVERSAL LIFE PRODUCT NAMES: <ul style="list-style-type: none"> • AccumUL Plus • Guaranteed Universal Life Survivor • Guaranteed Universal Life • Guaranteed Universal Life Plus <input type="checkbox"/> UNIVERSAL LIFE RIDER NAMES: <ul style="list-style-type: none"> • Accidental Death Benefit Rider • Dependent Children's Rider • Disability Rider <input type="checkbox"/> ACCUMUL PLUS ONLY: <ul style="list-style-type: none"> • Additional Insured Rider Self • Additional Insured Rider Spouse • Additional Insured Rider Other Insured <input type="checkbox"/> Guaranteed Universal Life SURVIVOR ONLY: <ul style="list-style-type: none"> • Four Year Level Term Insurance Rider • For 2nd Insured – Place their information in PART 1A PAGE 2 of 2 in section "RIDER ON OTHER PROPOSED INSURED" 	<input type="checkbox"/> TERM LIFE PRODUCT NAMES: <ul style="list-style-type: none"> • Term Life Answers • Term Life Complete ★ \$400,001 and above <input type="checkbox"/> TERM LIFE RIDER NAMES: <ul style="list-style-type: none"> • Accidental Death Benefit Rider • Children's Rider <input type="checkbox"/> TERM LIFE ANSWERS ONLY: <ul style="list-style-type: none"> • Other Insured Rider • Waiver of Premium Rider <input type="checkbox"/> TERM LIFE COMPLETE ONLY: <ul style="list-style-type: none"> • Disability of Waiver of Premium Rider
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SUPPLEMENTAL APPLICATIONS – This application package Does Not contain the following forms:

<input type="checkbox"/> <u>Disability Waiver of Premium Rider Application</u> Complete if applying for the Disability Rider, Waiver of Premium Rider or the Disability Waiver of Premium Rider	<input type="checkbox"/> <u>Children's Rider Application</u> Complete if Applicable	<input type="checkbox"/> <u>Juvenile Application</u> Complete if Proposed Insured is age 0-17 years
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APPLICATION SUBMISSION GUIDELINES – This application package Does Not contain the Buyer's Guide

- Attach a cover letter or additional information as needed
- Always submit the Producer Statement and Producer Report page
- Always obtain signed MIB and HIPAA authorizations
- Always provide client with MIB Inc Pre-Notice, Fair Credit Reporting Act Disclosure Statement, Notice of Information Practices, Investigative Consumer Reports Notice, Summary of Rights, and Life Insurance Buyer's Guide
- All changes should be initialed by the Applicant / Owner
- If a Financial Institution would receive compensation for a sale, the Financial Institution Consumer Disclosure must be signed by the client

IMPORTANT FORMS – This application package Does Not contain the Acknowledgement Form

- Bank Service Plan – Indicate whether the full modal premium was submitted by checking the appropriate box on the Monthly Bank Withdrawals form.
- Conditional Receipt Reminders – If money can be collected, the Conditional Receipt must be completed, dated and signed by the Producer and the Applicant / Owner
- Submit a signed Accelerated Benefit Rider Disclosure Form for AccumUL Plus, GUL, and GUL Plus
- Submit a signed HIV consent form, if applicable
- Submit a copy of the illustration or the acknowledgement form
- If face amount is \$1,000,000 and above and the Proposed Insured is age 65, or over you will need: (a) signed Statement of Policyowner form and, (b) signed Premium Funding and Acknowledgement form

REPLACEMENT FORMS

- Submit a signed Y5415_0403 "Definition of Replacement" form. This form must be completed **even if this is not a replacement**. If replacement is involved follow the Regulation 60 Replacement Guidelines. Replacement forms can be ordered in a packet or printed through Sales Professional Access

PARAMEDICAL VENDORS APPS – 1-800-635-1677 EMSI – 1-800-872-3674 EXAMONE – 1-877-933-9261 PORTAMEDIC – 1-800-765-1010 SUPERIOR MOBILE MEDICS – 1-800-898-3926	 INDICATE UNDERWRITING REQUIREMENTS INITIATED OR, COMPLETED ON THE PROPOSED INSURED(S) Primary Proposed Insured <ul style="list-style-type: none"> <input type="checkbox"/> Blood Profile <input type="checkbox"/> Physical Data <input type="checkbox"/> Urinalysis <input type="checkbox"/> Long Form Exam <input type="checkbox"/> MD Exam <input type="checkbox"/> Treadmill EKG <input type="checkbox"/> EKG 	Other Proposed Insured: <ul style="list-style-type: none"> <input type="checkbox"/> Blood Profile <input type="checkbox"/> Physical Data <input type="checkbox"/> Urinalysis <input type="checkbox"/> Long Form Exam <input type="checkbox"/> MD Exam <input type="checkbox"/> Treadmill EKG <input type="checkbox"/> EKG
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PART 1A, PAGE 2 OF 2 LIFE INSURANCE APPLICATION

OTHER COVERAGE INFORMATION

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

Company	Policy or Contract Number	Face Amount	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?	Date Sold
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

COMMENTS

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

RIDER ON OTHER PROPOSED INSURED

Other Proposed Insured Legal Name _____

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

Date of Birth _____ State of Birth _____ Annual Income _____

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

Legal Residence Address _____

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

If Other Proposed Insured is Age 0-17 Also Complete Juvenile Supplemental Application

Occupation/Duties _____ Employer _____

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

If more space is needed, provide information in Comments section

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PART 1B, PAGE 1 OF 1 LIFE INSURANCE APPLICATION

NON-MEDICAL UNDERWRITING		Proposed Insured	Other Proposed Insured Rider		
	1. Are the persons proposed for insurance citizens of the United States? If "No," complete the Foreign National and Foreign Travel questionnaire.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	2. Has any person proposed for insurance ever used (a) any form of tobacco, or (b) any form of nicotine replacement therapy? If "Yes," to question 2, please list details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Person Proposed for Insurance	Form of Tobacco/Nicotine Replacement Therapy	Number per Day	Date Stopped	
FINANCES	3. Has any person proposed for insurance: If answered "Yes," please list details in the Comments section.				
	(a) had life insurance coverage declined, postponed, or limited, or been denied reinstatement, or asked to pay extra premium by any insurance company?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(b) engaged in any hazardous sports, or activities within the last three years, such as motor sports racing, boat racing, parachuting, hang gliding, rock or mountain climbing, skydiving, skin diving or scuba diving, cliff diving, base jumping or bungee jumping, or plan such activity in the next two years?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(c) any intention of traveling, or living outside the USA, or Canada in the next two years? If "Yes," complete the Foreign National and Foreign Travel questionnaire.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(d) flown as a civilian pilot, student pilot, or crew member within the last three years, or plan such activity in the next two years? If "Yes," complete the Aviation questionnaire.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(e) within the last five years (1) been convicted of two or more moving violations, or (2) been convicted of driving under the influence of alcohol, or drugs, or (3) had a driver's license suspended, or revoked?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(f) been convicted of a felony?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(g) been on probation within the last 12 months, or are currently on probation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4. Has any person proposed for insurance ever filed for bankruptcy? If "Yes," please provide type(s) and date(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5. What is the purpose of this insurance (e.g., income replacement, mortgage protection, key person, buy-sell)? _____				
6. If applying for \$500,000 or more, complete box(es) below.					
Person Proposed for Insurance	Total Assets	Total Liabilities	Net Worth	Earned Income	Unearned Income
FAMILY HISTORY	7. Family History – Please list details below for both Proposed Insured and Other Proposed Insured (if applicable), or if not applicable check here <input type="checkbox"/>				
		Age at Death	Age at Death	If Deceased, Cause of Death	
		Proposed Insured	Other Proposed Insured	Proposed Insured	Other Proposed Insured
	Father				
	Mother				
	Sibling 1				
	Sibling 2				
Sibling 3					

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PART 2, PAGE 1 OF 3 LIFE INSURANCE APPLICATION

MEDICAL UNDERWRITING	1. Does any person proposed for insurance currently have a personal physician?			Proposed Insured <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Proposed Insured Rider <input type="checkbox"/> Yes <input type="checkbox"/> No
	Person Proposed for Insurance	Name, Address and Telephone Number of Personal Physician	Date last seen	State Reason, Findings and Treatment	
	2. Has any person proposed for insurance ever been diagnosed or treated as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) by a member of the medical profession?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Has any person proposed for insurance ever (a) received treatment for, or (b) been advised by a member of the medical profession to seek treatment regarding:				
	(a) any disease, or abnormal condition of the heart, circulatory system, or blood vessels, including high blood pressure, abnormal heart rhythm, valvular disease, or murmur, coronary artery blockage, chest pain, or stroke/mini-stroke?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(b) any disease of the lungs, or respiratory system, including tuberculosis, asthma, chronic bronchitis, emphysema, or shortness of breath?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(c) any digestive system disease, including ulcer, abdominal, or stomach pain, liver, or gallbladder disease, hepatitis, cirrhosis, colitis, or other colon, intestinal, or rectal disorder?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(d) any urinary, or reproductive system disease including protein, blood, or sugar in the urine; tumor, cysts, infection, or failure of the kidney; tumor, or disease of the prostate, testis, breasts, uterus, or ovaries?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(e) any brain, nerve, or mental disorder, including convulsions/epilepsy, headaches, blackouts, tremors, balance disorders, multiple sclerosis, paralysis, dementia, depression, or schizophrenia?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(f) any bone, or joint disorder, arthritis, or rheumatic conditions, including lupus, rheumatoid arthritis, scleroderma, fibromyalgia, or other bodily deformity, amputation, back, or spinal disorder?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(g) any disease, or disorder of vision, or hearing?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(h) cancer, tumor, blood/bleeding disorder, diabetes, thyroid, or other glandular/metabolic disorder excluding HIV tests?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 10 years, has any person proposed for insurance					
(a) used alcohol to a degree that required treatment, or been advised to limit, or discontinue its use by a physician, or other health care provider?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(b) used unlawful drugs in any form (including cocaine, marijuana, methamphetamines and hallucinogens), or used prescription drugs other than as prescribed (including sedatives, tranquilizers, or narcotics) in any form?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) been, or are currently a member of Alcoholics Anonymous, or Narcotics Anonymous?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. In the past 12 months, has any person proposed for insurance:					
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(a) required the assistance of another person, or a device of any kind for bathing, dressing, eating, toileting, getting in and out of a chair or bed, or the management of bowel, or bladder problems?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(c) used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
(d) applied for, received, or are you currently receiving disability, hospital, or medical benefits from any insurance company, government, employer, or other source other than for maternity?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PART 2, PAGE 3 OF 3 LIFE INSURANCE APPLICATION

AGREEMENT

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

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

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

Signed at: _____ Date _____
 City State Mo Day Yr

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

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

 Signature of Other Proposed Insured age 14½ and over .

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

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

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

PRODUCER STATEMENT:

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

 Signature of Producer Date _____
 Mo Day Yr

 Signature of Producer Date _____
 Mo Day Yr

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Producer Report

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

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

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

Full Name _____ Address _____ Birth Date _____

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

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

3. Are you related to the Proposed Primary Insured or Owner? Yes No

If answered "Yes," state relationship _____

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

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

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

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

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

9. Rate class quoted _____

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

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

Address	From	To

Additional Comments

Division Office/Brokerage General Agency/Bank Information

Printed Name of Producer _____

Printed Name of Producer _____

Commission % Share _____

Commission % Share _____

Phone No. _____

Phone No. _____

E-mail Address _____

E-mail Address _____

Date _____

Date _____

PLEASE SUBMIT ALL PAGES

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COMPANION LIFE INSURANCE COMPANY

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CONDITIONAL RECEIPT

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

A check dated _____ for \$ _____ from _____
Mo Day Yr
covering the lives of _____ accompanies this Receipt.
(Person(s) Proposed for Insurance)

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

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

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

- (1) The check submitted or the authorization and account number provided is sufficient to pay the first modal premium.
- (2) The date of the medical exam, or the date of the second medical exam if required must be completed within 60 days from the date of the application.
- (3) Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to Companion Life Insurance Company's published underwriting rules then in effect, without modification of the plan, premium rate, benefits, class and amount of coverage applied for.
- (4) To the best knowledge and belief of those signing the application all the statements and answers in the application are true and complete when made.
- (5) All parts of the application, and if required, supplements to the application, questionnaires and amendments to the application are completed and received by Companion Life Insurance Company.

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

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

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

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

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

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

Signed at: _____ Date _____
City State Mo Day Yr

Signature of Proposed Insured Age 14½ and over

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

Signature of Other Proposed Insured Age 14½ and over

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

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

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New York – Authorization To Disclose Personal Information To Companion Life Insurance Company

Meanings of Terms

“Medical Persons and Entities” means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

“Personal Information” means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me and, if my children are proposed insureds, my children also. Personal Information does not include Psychotherapy Notes.

“Psychotherapy Notes” means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person’s medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

“Specified Companies” means:

- The group of companies which presently includes Mutual of Omaha Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me and, if my children are proposed insureds, about my children to Companion Life Insurance Company.

Purposes

The Personal Information will be used to determine my or my children’s eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on this application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential For Redisclosure

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 then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

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

Expiration and Revocation

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:

ATTN: Individual Underwriting
Companion Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001

I realize that my right to revoke this authorization is limited to the extent that Companion Life Insurance Company has taken action in reliance on the authorization or the law allows Companion Life Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

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

Names and Signatures

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

Printed Name of Proposed Insured

Spouse’s Printed Name
(If Proposed Insured)

If children are to be insured, their printed
names

Signature of Proposed Insured

Signature of Spouse
(If Proposed Insured)

Signature of Parent or Guardian
(If Proposed Insured is a Minor)

Date

Date

Date

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

PLEASE SUBMIT ALL PAGES

MLU23376_NY_0603

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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 also authorize Companion Life Insurance Company and its reinsurers to disclose Personal Information about me and my children under the age of 18, if they are proposed insureds, 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: _____

Signature of Proposed Insured

Date _____
Mo Day Yr

Signature of Other Proposed Insured

Date _____
Mo Day Yr

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

Date _____
Mo Day Yr

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



Accelerated Death Benefit For Terminal and Chronic Illness Rider Disclosure

If the Net Accelerated Death Benefit Payment is paid under the terms of this Rider, the life insurance policy to which this Rider is attached will remain in force with reduced values and a reduced death benefit. The Net Accelerated Death Benefit Payment may be taxable. Receipt of this benefit may adversely affect Your eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting this benefit.

This Rider is a part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the Rider provisions. If the provisions of the Rider and those of the policy do not agree, the provisions of the Rider apply. This Rider is effective on the policy's date of issue.

Accelerated Benefit

While this rider is in force, you may choose to receive the Accelerated Death Benefit if the Insured is diagnosed as Terminally Ill or Chronically Ill. This disclosure provides a brief description of the Rider benefits.

Accelerated Death Benefit means a benefit requested under the Chronic Illness Benefit provision or Terminal Illness Benefit provision of this Rider.

Chronically Ill means the Insured has been certified by a Licensed Health Care Practitioner as: (a) having any condition that requires continuous care for the remainder of the Insured's life in an Eligible Facility or at home; and (b) being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity.

Terminally Ill means a Physician has certified that the Insured has a medical condition where the life expectancy of the Insured will not exceed 12 months from the date of the certification.

While this Rider is in force, You may choose to request the Accelerated Death Benefit if the Insured is certified as being Chronically Ill or Terminally Ill. You may request a Chronic Illness Accelerated Death Benefit no more than once per calendar year, and there must be at least 12 months between acceleration requests. Only one Terminal Illness Accelerated Death Benefit is payable under this Rider.

The Chronic Illness Accelerated Death Benefit that You request will be reduced by an actuarially discounted amount determined by Us. The actuarially discounted amount will be calculated by us using the life expectancy of the Insured as of the date the Chronic Illness Accelerated Death Benefit is requested and an Interest Rate that will not exceed the greater of:

- (a) the current yield of the 90-day U.S. treasury bills as of the date of the Accelerated Death Benefit request; or
- (b) the current maximum statutory adjustable policy loan interest rate based on the greater of:
 - the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the accelerated death benefit amount; and
 - the Guaranteed Minimum Interest Rate Credited to the Accumulation Value, plus 1%

The Terminal Illness Accelerated Death Benefit that You request will be reduced by an actuarially discounted amount equal to the requested Accelerated Death Benefit multiplied by the lesser of:

- (a) 6%; or,
- (b) the greater of:
 - (i) the current yield of the 90-day U.S. treasury bills as of the date of the Accelerated Death Benefit request; or
 - (ii) the current maximum statutory adjustable policy loan interest rate based on the greater of:
 - the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the Accelerated Death Benefit; and
 - the Guaranteed Minimum Interest Rate Credited to the Accumulation Value, plus 1%.

There will be \$100 charge for each Accelerated Death Benefit requested under this Rider. There is no premium or cost of insurance charge the Accelerated Death Benefit for Terminal or Chronic Illness Rider.

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Effect of the Benefit Payment

Only one Terminal Illness Accelerated Death Benefit is payable under this rider. You may choose to accelerate benefits for Chronic Illness multiple times, but may do so once per calendar year, and there must be at least 12 months between accelerations requests. The Net Accelerated Death Benefit Payment for Chronic Illness shall be no greater than the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the Insured is expected to be Chronically Ill. If the Insured is Chronically Ill for only part of a calendar year, the Chronic Illness Net Accelerated Death Benefit Payment will not be payable for the period during which the Insured was not Chronically Ill. In 2011, the per diem allowance generally equals \$300 per day or the equivalent amount in the case of payments on another periodic basis. The sum of all Accelerated Death Benefits requested under this Rider may not exceed the lesser of:

- (a) \$250,000; or
- (b) the Specified Amount as of the initial Accelerated Death Benefit request, minus the minimum Specified Amount as stated in the Change in Specified Amount provision of Your policy.

If a Change in Specified Amount provision is not provided in Your policy, the sum of all Accelerated Death Benefits requested under this Rider may not exceed the lesser of:

- (a) \$250,000; or
- (b) the Specified Amount as of the initial Accelerated Death Benefit request, minus \$5,000.

If You request a Terminal Illness Accelerated Death Benefit, this Rider will terminate immediately upon payment of the Terminal Illness Net Accelerated Death Benefit Payment.

The following adjustments are made to Your policy due to payment of a Net Accelerated Death Benefit Payment:

- (a) the current Specified Amount, current accumulation value, and any outstanding loans and loan interest due will be reduced by the same percentage that the Accelerated Death Benefit requested reduces the current death benefit; and
- (b) any future monthly deductions and cost of insurance charges will be based on the reduced amount of insurance.

Planned premiums are not automatically reduced as a result of payment of a Net Accelerated Death Benefit Payment. If Your policy provides a Paid-Up Option provision, the right to Accelerated Death Benefits will continue during any nonforfeiture reduced paid-up period. Accidental death benefit coverage, if available on Your policy, will not be affected by payment of a Net Accelerated Death Benefit Payment.

Applicant's Signature

Date

Applicant's Signature

Date

I have provided this Disclosure Form to the Applicant.

Producer's Signature

Date

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



NOTICE AND CONSENT FOR TESTING WHICH MAY INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING

- ATTN: Life Agency:
Individual Life Underwriting, 9330 State Hwy 133, NE 68008
- ATTN: Life Brokerage:
Individual Life Underwriting, 9330 State Hwy 133, NE 68008
- ATTN: Health:
PO Box 2351 Omaha, NE 68172

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

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

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

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

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

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Notification of Test Results

A positive test result will be disclosed to a physician or other individual you designate. If you do not designate anyone, a positive test result will be disclosed to you. However, because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician or other designee for reporting a positive test result _____

Address _____

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

Consent

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

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This form will not attach to or become part of the policy.

Name of Proposed Insured _____

Address _____

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

Date Signed

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



INSURANCE DEPARTMENT 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 Department Regulation No. 60 has occurred or is likely to occur and your agent or broker is required to provide you with a completed Disclosure Statement and the **Important** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts.

If you are replacing list the form number(s) and brief description(s) of preprinted or electronic sales material which was presented or check "NONE" box if no sales material was used in this sale: NONE

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/Broker: _____

CLIENT COPIES

PLEASE PROVIDE THE CLIENT WITH THE FOLLOWING FORMS. THEY DO NOT NEED TO BE SIGNED.

EXCEPT:

Definition of Replacement Form – Y5415_0403

You and the applicant must sign the customer copy of the Definition of Replacement Form.

Additional Instructions:

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

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

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



CONDITIONAL RECEIPT

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

A check dated _____ for \$ _____ from _____
Mo Day Yr
covering the lives of _____ accompanies this Receipt.
(Person(s) Proposed for Insurance)

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

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

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

- (1) The check submitted or the authorization and account number provided is sufficient to pay the first modal premium.
- (2) The date of the medical exam, or the date of the second medical exam if required must be completed within 60 days from the date of the application.
- (3) Each person proposed for insurance is, as of the application date, eligible for the exact policy applied for, according to Companion Life Insurance Company's published underwriting rules then in effect, without modification of the plan, premium rate, benefits, class and amount of coverage applied for.
- (4) To the best knowledge and belief of those signing the application all the statements and answers in the application are true and complete when made.
- (5) All parts of the application, and if required, supplements to the application, questionnaires and amendments to the application are completed and received by Companion Life Insurance Company.

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

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

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

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

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

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

Signed at: _____ Date _____
City State Mo Day Yr

Signature of Proposed Insured Age 14½ and over

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

Signature of Other Proposed Insured Age 14½ and over

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

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

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



Accelerated Death Benefit For Terminal and Chronic Illness Rider Disclosure

If the Net Accelerated Death Benefit Payment is paid under the terms of this Rider, the life insurance policy to which this Rider is attached will remain in force with reduced values and a reduced death benefit. The Net Accelerated Death Benefit Payment may be taxable. Receipt of this benefit may adversely affect Your eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting this benefit.

This Rider is a part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the Rider provisions. If the provisions of the Rider and those of the policy do not agree, the provisions of the Rider apply. This Rider is effective on the policy's date of issue.

Accelerated Benefit

While this rider is in force, you may choose to receive the Accelerated Death Benefit if the Insured is diagnosed as Terminally Ill or Chronically Ill. This disclosure provides a brief description of the Rider benefits.

Accelerated Death Benefit means a benefit requested under the Chronic Illness Benefit provision or Terminal Illness Benefit provision of this Rider.

Chronically Ill means the Insured has been certified by a Licensed Health Care Practitioner as: (a) having any condition that requires continuous care for the remainder of the Insured's life in an Eligible Facility or at home; and (b) being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity.

Terminally Ill means a Physician has certified that the Insured has a medical condition where the life expectancy of the Insured will not exceed 12 months from the date of the certification.

While this Rider is in force, You may choose to request the Accelerated Death Benefit if the Insured is certified as being Chronically Ill or Terminally Ill. You may request a Chronic Illness Accelerated Death Benefit no more than once per calendar year, and there must be at least 12 months between acceleration requests. Only one Terminal Illness Accelerated Death Benefit is payable under this Rider.

The Chronic Illness Accelerated Death Benefit that You request will be reduced by an actuarially discounted amount determined by Us. The actuarially discounted amount will be calculated by us using the life expectancy of the Insured as of the date the Chronic Illness Accelerated Death Benefit is requested and an Interest Rate that will not exceed the greater of:

- (a) the current yield of the 90-day U.S. treasury bills as of the date of the Accelerated Death Benefit request; or
- (b) the current maximum statutory adjustable policy loan interest rate based on the greater of:
 - the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the accelerated death benefit amount; and
 - the Guaranteed Minimum Interest Rate Credited to the Accumulation Value, plus 1%

The Terminal Illness Accelerated Death Benefit that You request will be reduced by an actuarially discounted amount equal to the requested Accelerated Death Benefit multiplied by the lesser of:

- (a) 6%; or,
- (b) the greater of:
 - (i) the current yield of the 90-day U.S. treasury bills as of the date of the Accelerated Death Benefit request; or
 - (ii) the current maximum statutory adjustable policy loan interest rate based on the greater of:
 - the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the Accelerated Death Benefit; and
 - the Guaranteed Minimum Interest Rate Credited to the Accumulation Value, plus 1%.

There will be \$100 charge for each Accelerated Death Benefit requested under this Rider. There is no premium or cost of insurance charge the Accelerated Death Benefit for Terminal or Chronic Illness Rider.

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Effect of the Benefit Payment

Only one Terminal Illness Accelerated Death Benefit is payable under this rider. You may choose to accelerate benefits for Chronic Illness multiple times, but may do so once per calendar year, and there must be at least 12 months between accelerations requests. The Net Accelerated Death Benefit Payment for Chronic Illness shall be no greater than the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the Insured is expected to be Chronically Ill. If the Insured is Chronically Ill for only part of a calendar year, the Chronic Illness Net Accelerated Death Benefit Payment will not be payable for the period during which the Insured was not Chronically Ill. In 2011, the per diem allowance generally equals \$300 per day or the equivalent amount in the case of payments on another periodic basis. The sum of all Accelerated Death Benefits requested under this Rider may not exceed the lesser of:

- (a) \$250,000; or
- (b) the Specified Amount as of the initial Accelerated Death Benefit request, minus the minimum Specified Amount as stated in the Change in Specified Amount provision of Your policy.

If a Change in Specified Amount provision is not provided in Your policy, the sum of all Accelerated Death Benefits requested under this Rider may not exceed the lesser of:

- (a) \$250,000; or
- (b) the Specified Amount as of the initial Accelerated Death Benefit request, minus \$5,000.

If You request a Terminal Illness Accelerated Death Benefit, this Rider will terminate immediately upon payment of the Terminal Illness Net Accelerated Death Benefit Payment.

The following adjustments are made to Your policy due to payment of a Net Accelerated Death Benefit Payment:

- (a) the current Specified Amount, current accumulation value, and any outstanding loans and loan interest due will be reduced by the same percentage that the Accelerated Death Benefit requested reduces the current death benefit; and
- (b) any future monthly deductions and cost of insurance charges will be based on the reduced amount of insurance.

Planned premiums are not automatically reduced as a result of payment of a Net Accelerated Death Benefit Payment. If Your policy provides a Paid-Up Option provision, the right to Accelerated Death Benefits will continue during any nonforfeiture reduced paid-up period. Accidental death benefit coverage, if available on Your policy, will not be affected by payment of a Net Accelerated Death Benefit Payment.

Applicant's Signature

Date

Applicant's Signature

Date

I have provided this Disclosure Form to the Applicant.

Producer's Signature

Date

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



INSURANCE DEPARTMENT 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 Department Regulation No. 60 has occurred or is likely to occur and your agent or broker is required to provide you with a completed Disclosure Statement and the **Important** Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts.

If you are replacing list the form number(s) and brief description(s) of preprinted or electronic sales material which was presented or check "NONE" box if no sales material was used in this sale: NONE

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/Broker: _____

COMPANION LIFE INSURANCE COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788

MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. Companion Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information is: 50 Braintree Hill Park, Suite 400, Braintree, MA 01284-8734.

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

Fair Credit Reporting Act Disclosure Statement

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

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

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

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

Notice of Information Practices

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

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

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

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

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

Investigative Consumer Reports Notice

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

A Summary of Your Rights Under the Fair Credit Reporting Act

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

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identify theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.
 In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.
- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

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

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

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



Accelerated Death Benefit For Terminal and Chronic Illness Rider Disclosure

If the Net Accelerated Death Benefit Payment is paid under the terms of this Rider, the life insurance policy to which this Rider is attached will remain in force with reduced values and a reduced death benefit. The Net Accelerated Death Benefit Payment may be taxable. Receipt of this benefit may adversely affect Your eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting this benefit.

This Rider is a part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the Rider provisions. If the provisions of the Rider and those of the policy do not agree, the provisions of the Rider apply. This Rider is effective on the policy's date of issue.

Accelerated Benefit

While this rider is in force, you may choose to receive the Accelerated Death Benefit if the Insured is diagnosed as Terminally Ill or Chronically Ill. This disclosure provides a brief description of the Rider benefits.

Accelerated Death Benefit means a benefit requested under the Chronic Illness Benefit provision or Terminal Illness Benefit provision of this Rider.

Chronically Ill means the Insured has been certified by a Licensed Health Care Practitioner as: (a) having any condition that requires continuous care for the remainder of the Insured's life in an Eligible Facility or at home; and (b) being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity.

Terminally Ill means a Physician has certified that the Insured has a medical condition where the life expectancy of the Insured will not exceed 12 months from the date of the certification.

While this Rider is in force, You may choose to request the Accelerated Death Benefit if the Insured is certified as being Chronically Ill or Terminally Ill. You may request a Chronic Illness Accelerated Death Benefit no more than once per calendar year, and there must be at least 12 months between acceleration requests. Only one Terminal Illness Accelerated Death Benefit is payable under this Rider.

The Chronic Illness Accelerated Death Benefit that You request will be reduced by an actuarially discounted amount determined by Us. The actuarially discounted amount will be calculated by us using the life expectancy of the Insured as of the date the Chronic Illness Accelerated Death Benefit is requested and an Interest Rate that will not exceed the greater of:

- (a) the current yield of the 90-day U.S. treasury bills as of the date of the Accelerated Death Benefit request; or
- (b) the current maximum statutory adjustable policy loan interest rate based on the greater of:
 - the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the accelerated death benefit amount; and
 - the Guaranteed Minimum Interest Rate Credited to the Accumulation Value, plus 1%

The Terminal Illness Accelerated Death Benefit that You request will be reduced by an actuarially discounted amount equal to the requested Accelerated Death Benefit multiplied by the lesser of:

- (a) 6%; or,
- (b) the greater of:
 - (i) the current yield of the 90-day U.S. treasury bills as of the date of the Accelerated Death Benefit request; or
 - (ii) the current maximum statutory adjustable policy loan interest rate based on the greater of:
 - the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the Accelerated Death Benefit; and
 - the Guaranteed Minimum Interest Rate Credited to the Accumulation Value, plus 1%.

There will be \$100 charge for each Accelerated Death Benefit requested under this Rider. There is no premium or cost of insurance charge the Accelerated Death Benefit for Terminal or Chronic Illness Rider.

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COMPANION LIFE INSURANCE COMPANY

[A MUTUAL of OMAHA COMPANY]

[888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788]



Accelerated Death Benefit For Terminal and Chronic Illness Rider Disclosure

If the Net Accelerated Death Benefit Payment is paid under the terms of this Rider, the life insurance policy to which this Rider is attached will remain in force with reduced values and a reduced death benefit. The Net Accelerated Death Benefit Payment may be taxable. Receipt of this benefit may adversely affect Your eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting this benefit.

This Rider is a part of the policy to which it is attached. It is subject to all of the policy provisions that are not inconsistent with the Rider provisions. If the provisions of the Rider and those of the policy do not agree, the provisions of the Rider apply. This Rider is effective on the policy's date of issue.

Accelerated Benefit

While this rider is in force, you may choose to receive the Accelerated Death Benefit if the Insured is diagnosed as Terminally Ill or Chronically Ill. This disclosure provides a brief description of the Rider benefits.

Accelerated Death Benefit means a benefit requested under the Chronic Illness Benefit provision or Terminal Illness Benefit provision of this Rider.

Chronically Ill means the Insured has been certified by a Licensed Health Care Practitioner as: (a) having any condition that requires continuous care for the remainder of the Insured's life in an Eligible Facility or at home; and (b) being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity.

Terminally Ill means a Physician has certified that the Insured has a medical condition where the life expectancy of the Insured will not exceed 12 months from the date of the certification.

While this Rider is in force, You may choose to request the Accelerated Death Benefit if the Insured is certified as being Chronically Ill or Terminally Ill. You may request a Chronic Illness Accelerated Death Benefit no more than once per calendar year, and there must be at least 12 months between acceleration requests. Only one Terminal Illness Accelerated Death Benefit is payable under this Rider.

The Chronic Illness Accelerated Death Benefit that You request will be reduced by an actuarially discounted amount determined by Us. The actuarially discounted amount will be calculated by us using the life expectancy of the Insured as of the date the Chronic Illness Accelerated Death Benefit is requested and an Interest Rate that will not exceed the greater of:

- (a) the current yield of the 90-day U.S. treasury bills as of the date of the Accelerated Death Benefit request; or
- (b) the current maximum statutory adjustable policy loan interest rate based on the greater of:
 - the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the accelerated death benefit amount; and
 - the Guaranteed Minimum Interest Rate Credited to the Accumulation Value, plus 1%

The Terminal Illness Accelerated Death Benefit that You request will be reduced by an actuarially discounted amount equal to the requested Accelerated Death Benefit multiplied by the lesser of:

- (a) 6%; or,
- (b) the greater of:
 - (i) the current yield of the 90-day U.S. treasury bills as of the date of the Accelerated Death Benefit request; or
 - (ii) the current maximum statutory adjustable policy loan interest rate based on the greater of:
 - the Moody's Corporate Bond Yield Averages-Monthly Average Corporates-published by Moody's Investors Services, Inc., or any successor thereto for the calendar month ending two months before the date of request for the Accelerated Death Benefit; and
 - the Guaranteed Minimum Interest Rate Credited to the Accumulation Value, plus 1%.

There will be \$100 charge for each Accelerated Death Benefit requested under this Rider. There is no premium or cost of insurance charge the Accelerated Death Benefit for Terminal or Chronic Illness Rider.

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Effect of the Benefit Payment

Only one Terminal Illness Accelerated Death Benefit is payable under this rider. You may choose to accelerate benefits for Chronic Illness multiple times, but may do so once per calendar year, and there must be at least 12 months between accelerations requests. The Net Accelerated Death Benefit Payment for Chronic Illness shall be no greater than the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the Insured is expected to be Chronically Ill. If the Insured is Chronically Ill for only part of a calendar year, the Chronic Illness Net Accelerated Death Benefit Payment will not be payable for the period during which the Insured was not Chronically Ill. In 2011, the per diem allowance generally equals \$300 per day or the equivalent amount in the case of payments on another periodic basis. The sum of all Accelerated Death Benefits requested under this Rider may not exceed the lesser of:

- (a) \$250,000; or
- (b) the Specified Amount as of the initial Accelerated Death Benefit request, minus the minimum Specified Amount as stated in the Change in Specified Amount provision of Your policy.

If a Change in Specified Amount provision is not provided in Your policy, the sum of all Accelerated Death Benefits requested under this Rider may not exceed the lesser of:

- (a) \$250,000; or
- (b) the Specified Amount as of the initial Accelerated Death Benefit request, minus \$5,000.

If You request a Terminal Illness Accelerated Death Benefit, this Rider will terminate immediately upon payment of the Terminal Illness Net Accelerated Death Benefit Payment.

The following adjustments are made to Your policy due to payment of a Net Accelerated Death Benefit Payment:

- (a) the current Specified Amount, current accumulation value, and any outstanding loans and loan interest due will be reduced by the same percentage that the Accelerated Death Benefit requested reduces the current death benefit; and
- (b) any future monthly deductions and cost of insurance charges will be based on the reduced amount of insurance.

Planned premiums are not automatically reduced as a result of payment of a Net Accelerated Death Benefit Payment. If Your policy provides a Paid-Up Option provision, the right to Accelerated Death Benefits will continue during any nonforfeiture reduced paid-up period. Accidental death benefit coverage, if available on Your policy, will not be affected by payment of a Net Accelerated Death Benefit Payment.

Applicant's Signature

Date

Applicant's Signature

Date

I have provided this Disclosure Form to the Applicant.

Producer's Signature

Date

Effect of the Benefit Payment

Only one Terminal Illness Accelerated Death Benefit is payable under this rider. You may choose to accelerate benefits for Chronic Illness multiple times, but may do so once per calendar year, and there must be at least 12 months between accelerations requests. The Net Accelerated Death Benefit Payment for Chronic Illness shall be no greater than the per diem allowance permitted by section 101(g)(3) of the Internal Revenue Code multiplied by the number of days in the current calendar year that the Insured is expected to be Chronically Ill. If the Insured is Chronically Ill for only part of a calendar year, the Chronic Illness Net Accelerated Death Benefit Payment will not be payable for the period during which the Insured was not Chronically Ill. In 2011, the per diem allowance generally equals \$300 per day or the equivalent amount in the case of payments on another periodic basis. The sum of all Accelerated Death Benefits requested under this Rider may not exceed the lesser of:

- (a) \$250,000; or
- (b) the Specified Amount as of the initial Accelerated Death Benefit request, minus the minimum Specified Amount as stated in the Change in Specified Amount provision of Your policy.

If a Change in Specified Amount provision is not provided in Your policy, the sum of all Accelerated Death Benefits requested under this Rider may not exceed the lesser of:

- (a) \$250,000; or
- (b) the Specified Amount as of the initial Accelerated Death Benefit request, minus \$5,000.

If You request a Terminal Illness Accelerated Death Benefit, this Rider will terminate immediately upon payment of the Terminal Illness Net Accelerated Death Benefit Payment.

The following adjustments are made to Your policy due to payment of a Net Accelerated Death Benefit Payment:

- (a) the current Specified Amount, current accumulation value, and any outstanding loans and loan interest due will be reduced by the same percentage that the Accelerated Death Benefit requested reduces the current death benefit; and
- (b) any future monthly deductions and cost of insurance charges will be based on the reduced amount of insurance.

Planned premiums are not automatically reduced as a result of payment of a Net Accelerated Death Benefit Payment. If Your policy provides a Paid-Up Option provision, the right to Accelerated Death Benefits will continue during any nonforfeiture reduced paid-up period. Accidental death benefit coverage, if available on Your policy, will not be affected by payment of a Net Accelerated Death Benefit Payment.

Applicant's Signature

Date

Applicant's Signature

Date

I have provided this Disclosure Form to the Applicant.

Producer's Signature

Date

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



STATEMENT OF POLICYOWNER INTENT

Required for all applications where the proposed insured for life insurance is age 65 and above and the proposed face amount is \$1,000,000 and above.

This form is to be attached to and made a part of the policy.

Companion Life Insurance Company does not issue insurance policies unsupported by an insurable interest, including any policies involved in stranger originated life insurance (“STOLI”) transactions. **STOLI is a practice or plan to initiate a life insurance policy for the benefit of a third party who, at the time of policy origination, has no insurable interest in the insured.**

Name of Owner/Applicant: _____

Name of Proposed Insured: _____

Questions to be answered by the owner/applicant and proposed insured (if different from owner/applicant):

1. Has the owner/applicant, proposed insured or any third party been offered any direct or indirect inducement to encourage the application for this life insurance policy, such as a cash payment, gift or loan proceeds?

Owner/Applicant Yes No

Proposed Insured Yes No

2. Is there an understanding in place or any kind of agreement that anyone other than the owner/applicant will obtain any right, title, or other legal or beneficial interest in this policy or the proceeds of this policy?

Owner/Applicant Yes No

Proposed Insured Yes No

3. Have you discussed or otherwise communicated with anyone about the possibility of selling or otherwise using this policy or any beneficial interest in this policy or the death proceeds from this policy for any type of STOLI, life settlement, viatical settlement, senior settlement or other secondary market or similar transaction?

Owner/Applicant Yes No

Proposed Insured Yes No

Please provide an explanation for any “Yes” answers above, including identification of all parties involved.

STATEMENT OF THE OWNER/APPLICANT AND PROPOSED INSURED:

I understand that Companion Life Insurance Company does not issue insurance policies unsupported by an insurable interest, including any policies involved in stranger originated life insurance (“STOLI”) transactions. All answers and information provided on this statement are true and complete to the best of my knowledge and belief and will be relied upon by Companion Life Insurance Company in deciding whether to issue this policy.

Signature of Owner/Applicant

Date

Signature of Proposed Insured
(if different from the Owner/Applicant)

Date

YA0175-1008

COMPANION LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

888 VETERANS MEMORIAL HIGHWAY, SUITE 515, HAUPPAUGE, NY 11788



PREMIUM FUNDING AND ACKNOWLEDGMENT FORM

Required for all applications where the proposed insured for life insurance is age 65 and above and the proposed face amount is \$1,000,000 and above.

This form is to be attached to and made a part of the policy.

We will screen for and reject any stranger originated life insurance (“STOLI”) policies, or policies using non-recourse premium financing. Non-recourse premium financing generally means an arrangement in which life insurance premiums are financed via a loan in which the borrower makes no personal guarantee and posts little or no collateral, other than the life insurance policy being financed as backing for the loan. STOLI is a practice or plan to initiate a life insurance policy for the benefit of a third party who, at the time of policy origination, has no insurable interest in the life of the insured. We will consider policies funded by traditional recourse premium financing programs in which:

- **The loan must be 100% collateralized by personal or business assets of the borrower**
- **If the life insurance policy is part of the collateral, only the cash surrender value of the policy may be considered**
- **We must be provided with full details regarding all aspects of the premium financing program**

Name of Owner/Applicant: _____

Name of Proposed Insured: _____

1. A. Do you plan to use any funds, other than your own, to pay the premium for any portion of the applied for life insurance? Yes No

If premiums are being provided by a third party, please provide the following information regarding the third party:

Name: _____

Address: _____

Relationship to Owner/Applicant: _____

Please submit a copy of the loan contract, agreement, term sheet, disclosure form and any other document(s) relating to or evidencing the transaction. If there is a trust involved, please provide a copy of the trust document.

- B. If you answered 1A as “Yes,” is any collateral, other than this life insurance policy required for this loan? Yes No

If “Yes,” please describe the collateral: _____

2. Owner/Applicant understands the following:

- Any lending institution from which you may obtain premium financing and Companion Life Insurance Company operate independently from each other and are separately responsible for their respective contractual and legal obligations.
- Companion Life Insurance Company is not a party to, or bound by, any of the provisions or representations relating to any premium financing arrangement related to the proposed life insured, except as may be required under any properly executed collateral assignment arrangements.
- If you finance the premium, you are solely responsible for the selection of the lender and negotiation of the terms of any loan or financing agreement.
- The factors used by Companion Life Insurance Company to determine your eligibility for life insurance coverage are separate and independent from those factors used by a lender to determine your eligibility for a loan.
- The terms of the life insurance policy are separate and distinct from the terms of a loan. Failure to pay sufficient premiums will result in loss of benefits under the terms of the life insurance policy.

The statements and answers in this supplement and any supporting documentation provided by me for use in conjunction with this supplement, are true and complete to the best of my knowledge and belief and will be relied upon by Companion Life Insurance Company in deciding whether to issue this policy.

Signature of Owner/Applicant

Date

Signature of Proposed Insured (if other than Owner/Applicant

Date

Signature of Producer

Date