Term Life Insurance Underwriting Guide
Term Life

This term life plan offers competitive premiums guaranteed to remain level for the length of the term. This plan can help families meet personal financial obligations if the insured is not there to provide for them. This plan is renewable at the end of each term up to age 95.

This plan also offers an Accelerated Death Benefit Rider. This rider is automatically included in the policy at no cost to the insured and will pay 25 percent of the death benefit if the insured is diagnosed as having a terminal illness. This benefit will only be paid once. The Accelerate Death Benefit amount will be reduced by any interest charge, administration fee, and unpaid premiums. If the insured elects to accelerate the benefit, the benefit paid upon their death will be reduced accordingly (not available in Pennsylvania and Texas).

In addition to the Term Life, the applicant can customize their coverage by adding the following riders to their policy at an addition cost:

- **Waiver of Premium** – The Waiver of Premium automatically pays policy premiums if the insured becomes totally disabled under the terms of the policy and coverage stops at the end of the term period or at age 65 which ever comes first.

- **Accidental Death Benefit** – The Accidental Death Benefit coverage pays an additional amount equal to the face amount selected if the insured’s death is the result of a covered accident and occurs within 180 days of the accident. Coverage stops at age 70.

The rates are sex and tobacco distinct and are based on 10, 15, 20 and 30 year terms. Refer to breakdown below under Plan Descriptions.

**Annual Policy Fee:** $50

**Modal Factors**
- Semi-Annually: 0.515
- Quarterly: 0.2625
- Monthly EFT: 0.08333

**Plan Descriptions:**

**Issue Ages**
- 18 to 65
- Male/Female
- Tobacco/Non-Tobacco

**Riders**
- Accelerated Death Benefit

**Optional Riders**
- Waiver of Premium
- Accidental Death Benefit

**Level Terms by Year**
- 10, 15, 20 Year Term – Age 18 to 65
- 30 Year Term – Age 18 to 50 (males)
- 30 Year Term – Age 18 to 55 (females)
Minimum Issue Limits

- Age 18 to 30 = $75,000
- Age 31 to 40 = $50,000
- Age 41 to 50 = $35,000
- Age 51 to 65 = $25,000

Non-Medical Underwriting up to $250,000 and quick issue

1. Full completed application
2. MIB
3. MVR
4. Prescription Database Check

$250,001 and above will require medical underwriting.

- $250,001 to $500,000
  - Age 18 to 40 requires P, HOS, BLD
  - Age 41 to 60 requires P, HOS, BLD, EKG
  - Age 61 to 65 requires MD, HOS, BLD, EKG

- $500,001 to $2,000,000
  - Age 18 to 40 requires P, HOS, BLD
  - Age 41 to 45 requires P, HOS, BLD, EKG
  - Age 46 to 65 requires MD, HOS, BLD, EKG

P = Paramed
MD = Physician Exam
HOS = Home Office Specimen
BLD = Blood Profile to Include HIV Test
EKG = Electrocardiogram
MVR = Motor Vehicle Report
RX = Prescription Database Check

Inspection Reports done on all cases over $500,000

To underwrite this product we use the debit/credit point system. The product underwriting guide is available on the Agents area of UCT’s website at www.uct.org.

UCT’s Term life offers two underwriting classes. Applicants may be eligible for one of the two underwriting levels depending on their state of health.

- Standard – standard risks through Table 4 (Table D / up to 100 debits)
- Sub-standard – risks from Table 5 through Table 8 (Table E – Table H / 101 to 200 debits)
  - If points exceed 200 debits or table 8, the application will be declined.
  1. If any one of the eligibility questions 1 – 8 is answered “yes” the applicant is not eligible for coverage.
  2. If any one of the health questions 9 – 14 is “yes” please provide details in the box provided.
  3. Initial premium is required at the time of submission. **DO NOT COLLECT INITIAL PREMIUM IN KANSAS.**
  4. All applications are subject to MIB (Medical Information Bureau).
  5. All applications are subject to a prescription drug search.
  6. All applications are subject to MVR (Motor Vehicles Report).
  7. We do not allow effective dates on the 29th, 30th, or 31st.
**Approved Paramedical Companies**

APPS (American Para Professional Services Inc.)
www.appsnational.com  (800) 727-2999

EMSI (Examination Management Services Inc.)
www.emsinet.com  (800) 472-0454

ExamOne
www.questdiagnostics.com  (877) 933-0454

Heritage Labs
www.heritagelabs.net  (888) 764-4120

All laboratory analysis will be conducted through Heritage Labs.
Before you start underwriting the application, do the following:

- **Run MIB.** If significant MIB hits show up, you can order any requirements you need to verify whether the MIB code is correct. If several recent insurance activity index (IAI) hits show up on the applicant but are not mentioned on the application, consider the possibility that the applicant is "shopping" for insurance (does he/she have a ratable condition?), or is he/she accumulating life policies to the point of over-insurance? Please note if the application isn’t signed and dated we cannot run the MIB check until we receive the signature. To be practical, we can ask for any underwriting requirements that we need at the same time we request the needed signature. For more complete information on MIB, see the MIB training manual.

- **Run IntelliScript (IA) report.** Check for significant medications and prescribing physician.

- **Run MVR through EMSI.** Check driving history for any suspension, DUIs, etc.

- **Personal History Interview** – Is not required; however, if any red flags come up from the IA report, MIB or MVR the underwriter should send for a PHI for additional information.

- **Check the product availability list for specific product forms, etc.** Check the app to make sure it is the current form for that state. Check for current replacement forms (if needed) and any other state-specific forms required.

### Administrative Forms

The following forms are necessary for a Term Life product. Please note there are state specific variations of some of these forms. The application is actually in a booklet format (TERM APP*). *means it could be state specific which will have a 2 letter initial of the state after the form number.

- Application Form (TERM APP 0610) State specific versions may apply.
- Accelerated Death Benefit Rider Discloser Statement (TERM ABR DS 0610)
- Replacement of Life Insurance or Annuities (LRF 2008) if required.
- Application for Membership (M-81 Rev. 11-10)

### Medical Conditions


Unit Premiums found in the Agent Field Guide, our website www.uct.org, or brochures (rates sheets).
Application

Requested Effective Date of Policy

This is required; however, if blank use the date the application was received at our office. Check the applicant’s birthday to make sure a current date will not change their age. Life policies can be backdated up to 6 months to save age if desired, but is rarely in the applicant’s best interest because he/she would have to pay that entire back premium for coverage he/she had not received. Although if the applicant is close to the age limit, this might be the only way to issue a policy in order to meet guidelines. Life policies should not be dated ahead for more than 15 days, usually if a replacement from another life product is involved. Optimum-Re would like to know the reason for a future effective date.

“Agent No.:” and “Print Agent Name:” are fields completed by the agent. Check the agent against the Agent Flag List. If he/she is on the list, check to see why. Watch for patterns of poor field underwriting and/or outright misrepresentation.

Proposed Insured Information

- Make sure the state listed matches the state specific application (if applicable).
- The applicant’s phone number is required in order to conduct a phone interview. The interview must always be completed by the applicant (if interview is required).
- Check occupation. Based on our Treaty with Optimum–Re it’s not required. However in our write up to Optimum-Re we should indicate if an applicant has a hazardous occupation. We should also inquire about any early retirement retirees (i.e. anyone under age 65)
- Date of birth must be completed - again, this is an identification issue for Claims as well as the correct rates for this product. If age field is left blank, DOB will help us determine it.
- Birth state is used to run MIB checks, but if it is not completed, do not worry about it. We would just input it as “unknown.”
- Gender is required.
- Height and weight is required. You may need to review the build chart if the weight is on either extreme (obesity or under-weight). If left blank, once the height/weight is obtained through a phone interview, an amendment (if approved for issue) may be required.
- The social security number is necessary and if missing we will need to send a requirement to obtain it. This is for identification purposes in case of a claim and for tax purposes.
- Driver’s license information (DL number and issue state) sections must be completed.
- Marital status is required.
- Tobacco use status is required (smoker vs. non-smoker).

Initial Beneficiary Designation

Insurable interest is required for both the beneficiary and 3rd party owner (except in California, where no insurable interest is required on applicants when the insured owns his/her own policy.) The agent should never be the beneficiary unless he/she is a close blood relative of the insured. If the agent is beneficiary and the reason given is “to cover a loan,” request a copy of the loan agreement to verify.
Member Information
This section has to do with the Fraternal Membership. If the applicant is a current fraternal member, the applicant should have the necessary information to complete this section. If the applicant is not currently a fraternal member, a completed M-81 form needs to be attached to the application.

Third Party Ownership
Complete this section only if the owner is someone other than the applicant.

Proposed Insurance Plan
This entire section must be completed because it determines what the premium will be. If you need help to determine the total modal premium you can go to our website at http://www.uct.org/term_life_calculator.html.

Eligibility Questions
If any one of the eligibility questions 1 - 8 is answered “yes” the applicant is not eligible for coverage and the agent should not submit the application. The underwriter will decline the Term Life application.

Health Questions
If any one of the health questions 9 - 14 is “yes”, make sure details are completed in the boxes provided.

Policy Information
Both replacement questions must be answered. If it’s a replacement situation, make sure the applicant provides the name of the company, policy number and reason for replacement in the section provided. A Replacement form (LRF 2008 - check for correct version as some are state specific) will also need to be completed. We are required by law to send out a replacement letter to the prior insurance carrier.

Authorizations and Signatures
This sections must be signed, dated and provide the city/state the application is signed by the applicant. If this section is not signed it will hold up the underwriting process.

Agent Certification
This section must be completed and signed by the agent. If this section is not completed it will hold up the issuing of the policy (if the application has been approved by underwriting).
**HIPAA & MIB Authorization and Acknowledgement**

This section must be completed by the applicant. If this section is not completed it will hold up the underwriting process and we cannot pull a MIB, MVR or an IntelliScript report.

The date the application was signed is required or an amendment will be needed. We expect the information to be current (within 30 days from the signature date). Over 30 days is not acceptable unless there were special circumstances (i.e. the original application was lost in the mail and the agent had to send us a copy).

The city and state where the application was signed is required or an amendment will be needed. The application must be signed in the state in which the agent is licensed or the application will be declined.

The signature of the proposed insured is required on this page. If the owner of the policy is not the insured, then the Owner must also sign the application.

The detachable notices should not be sent in with the application, but if the notices are, don’t worry about it.

**Authorization to My Bank**

If the applicant is paying by Electronic Funds Transfer (EFT) also known as automatic bank draft, then a voided check is required.

**Note:** The underwriter will review and underwrite the application first and may write up our recommendation for Optimum-Re to review asking for their final decision. Face amounts under $250,000 will be reviewed and accepted or declined by our UCT underwriters. Those applying for $250,001 or greater in life insurance coverage are all forwarded to Optimum-re for approval.
## 1. PROPOSED INSURED AND BENEFICIARY INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>RESIDENCE ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Street:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City:</td>
</tr>
</tbody>
</table>

**OCCUPATION**

*Description: ____________________________*

*Name of Employer: ____________________________*

*Address: ____________________________*

*Telephone: (_______)*

<table>
<thead>
<tr>
<th>AGE</th>
<th>DATE OF BIRTH</th>
<th>BIRTH STATE</th>
<th>SEX</th>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>SOCIAL SECURITY NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month  Day Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Driver’s License Number: ____________________________*

*Driver’s License State: ____________________________*

*Marital Status:*

- [ ] Married
- [ ] Widowed
- [ ] Single
- [ ] Divorced

*Has the Proposed Insured used any form of tobacco in the past two years? ____________________________*  
- [ ] Yes
- [ ] No

### Primary Beneficiary

- [ ]

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### Percentage of Death Benefit

<table>
<thead>
<tr>
<th>Name (Last, First, MI) or Non-Natural Entity Name</th>
<th>Social Security No. / Tax I.D.</th>
<th>Relationship to Proposed Insured</th>
</tr>
</thead>
</table>

### Additional Beneficiary

- [ ]

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### Percentage of Death Benefit

<table>
<thead>
<tr>
<th>Name (Last, First, MI) or Non-Natural Entity Name</th>
<th>Social Security No. / Tax I.D.</th>
<th>Relationship to Proposed Insured</th>
</tr>
</thead>
</table>

**ADD ADDITIONAL SHEET FOR MORE BENEFICIARIES**

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**Are you a member of The Order of United Commercial Travelers of America? ____________________________**  
- [ ] Yes
- [ ] No

*Member Number: ____________________________*

If “No” checked above, complete membership form (M-81).

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## 2. OWNER (If other than Proposed Insured)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Social Security No. / Tax I.D.</th>
<th>Relationship to Proposed Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

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TERM APP 0610

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Rev. 8/13

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### 3. PROPOSED INSURANCE PLAN

<table>
<thead>
<tr>
<th>Type Plan</th>
<th>Face Amount</th>
<th>Premium</th>
<th>Premium Mode:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term Life</td>
<td>$__________</td>
<td>$__________</td>
<td>□ Annual □ Semi-Annual</td>
</tr>
<tr>
<td>Initial Term Period:</td>
<td>□ 10 Yrs □ 15 Yrs □ 20 Yrs □ 30 Yrs</td>
<td></td>
<td>□ Quarterly □ Monthly EFT *</td>
</tr>
<tr>
<td>Riders:</td>
<td>□ Accidental Death Benefit $__________</td>
<td></td>
<td>* Electronic Funds Transfer</td>
</tr>
<tr>
<td></td>
<td>□ Waiver of Premium $__________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Accelerated Death Benefit $__________</td>
<td></td>
<td>Annual Policy Fee: $50.00</td>
</tr>
</tbody>
</table>

**Sum Paid with Application $__________**  **Total Modal Premium $__________**  
*(Receipt valid only if amount paid with application is entered here)*

Will the Premium be paid by the Proposed Insured or the Owner? □ Yes □ No  
*If “No” please complete the Payor’s information below:*

<table>
<thead>
<tr>
<th>Payor’s Name</th>
<th>Payor’s Address (number and street, city, state, zip code)</th>
</tr>
</thead>
</table>

### 4. ELIGIBILITY QUESTIONS

*(If any question in this section is answered “yes”, the Proposed Insured is not eligible for coverage)*

1. Has the Proposed Insured ever tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection, or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immunodeficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection? □ Yes □ No

2. Is the Proposed Insured currently bedridden, receiving home health care, hospitalized, confined to a nursing home or long-term care facility, or been advised in the past 6 months to be hospitalized or to go into a nursing home or long-term care facility and refused? □ Yes □ No

3. Is the Proposed Insured in the end stages of a terminal illness, or been told his/her life expectancy is 12 months or less, or receiving or on the waiting list for hospice care? □ Yes □ No

4. Is the Proposed Insured currently awaiting an organ transplant? □ Yes □ No

5. Within the past 2 years, has the Proposed Insured:
   (a) been administered oxygen or recommended the use of oxygen? □ Yes □ No
   (b) had a heart attack, stroke, transient ischemic attack (TIA, also known as a mini-stroke), had or been advised to have heart surgery (including angioplasty or stent placement)? □ Yes □ No

6. Within the past 2 years, has the Proposed Insured been diagnosed with or treated for:
   (a) dementia, Alzheimer’s disease, schizophrenia, or any mental disorder? □ Yes □ No
   (b) cancer (other than basal cell carcinoma), leukemia, lymphoma, tumor, or chronic blood disorder (including sickle cell anemia)? □ Yes □ No

7. In the past 5 years, has the Proposed Insured been incarcerated? □ Yes □ No

8. Has the Proposed Insured ever been diagnosed with or treated for:
   (a) chronic kidney disease or disorder, or received kidney dialysis? □ Yes □ No
   (b) hepatitis (except Hepatitis A), or any liver or pancreas disease? □ Yes □ No
   (c) Congestive Heart Failure (CHF)? □ Yes □ No
   (d) Multiple sclerosis, lupus, or ALS (also known as Lou Gehrig’s disease)? □ Yes □ No

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**TERM APP 0610**  
**Page 2**
5. HEALTH QUESTIONS
(If “yes”, please provide details – attach additional sheet if necessary)

9. In the past 2 years, has the Proposed Insured had an application for life or health insurance or reinstatement declined, rated, or modified in any way? ................................................................. □ Yes □ No

10. Has any Proposed Insured ever been diagnosed with, been treated by a member of the medical profession, taken medication for, or been advised to have diagnostic tests for: (check applicable conditions)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
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</thead>
<tbody>
<tr>
<td>Internal cancer</td>
<td>Heart Attack</td>
</tr>
<tr>
<td>Leukemia</td>
<td>Stroke</td>
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<tr>
<td>Lymphoma</td>
<td>Transient Ischemic Attack</td>
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<tr>
<td>Hodgkin’s disease</td>
<td>Heart Surgery</td>
</tr>
<tr>
<td>Malignant melanoma</td>
<td>Coronary Artery Surgery</td>
</tr>
<tr>
<td>Dementia, Alzheimer’s or Parkinson’s disease</td>
<td>Heart or circulatory system disease</td>
</tr>
<tr>
<td>Malignant or benign tumors of any kind</td>
<td>Angioplasty</td>
</tr>
<tr>
<td>Emphysema or other chronic lung disease</td>
<td>Paralysis, epilepsy, or other nervous system disease</td>
</tr>
<tr>
<td>Blood disorder</td>
<td>Diabetes Mellitus</td>
</tr>
</tbody>
</table>

11. Does the Proposed Insured require the use of a wheelchair due to chronic illness? ................................................ □ Yes □ No

12. In the last 2 years, has the Proposed Insured had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? .......................................................... □ Yes □ No

13. In the past 3 years, has the Proposed Insured been treated for alcohol and/or drug abuse? ........................................ □ Yes □ No

14. In the past 3 years, has the Proposed Insured been convicted of or put on probation for: (1) a felony; (2) driving under the influence (DUI); or (3) driving while intoxicated (DWI)? ........................................ □ Yes □ No

Give details to any “Yes” answers to the Health Questions

<table>
<thead>
<tr>
<th>Question No.</th>
<th>Explanation (including Medications)</th>
<th>Dates / Duration</th>
<th>Name of Physician and/or Hospital</th>
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With Regard to Phone Interviews:

Daytime Phone No: _______________________________ Best Time to Call: _______________________________

6. REPLACEMENT INFORMATION

a. Does the Proposed Insured have any existing life insurance or annuities currently in force or pending with this or any other company? .................................................................................................................. □ Yes □ No

b. Will this policy, if issued, replace or modify insurance or annuities with this or any other company? ............................................. □ Yes □ No

If “yes”, provide the following information:

Name of Company ____________________________ Policy No. ____________________________

Reason for replacement! ____________________________
7. AUTHORIZATIONS AND SIGNATURES

I hereby apply to The Order of United Commercial Travelers of America for a policy to be issued solely and entirely in reliance on my written answers to the questions on this application. The answers are, to the best of my knowledge and belief, true. The Order of United Commercial Travelers of America has the right to deny benefits or rescind my Policy. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy. I agree the policy shall not be effective until it has actually been issued.

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

Signed At: ___________________________ Applicant’s Signature: ___________________________

Dated: _______________________________
(Month/Day/Year)

8. AGENT’S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other life insurance or annuity policies you have sold to the Applicant that are still in force.

____________________________________

2. List any other life insurance or annuity policies you have sold to the Applicant in the past five (5) years that are no longer in force.

____________________________________

3. Do you have any knowledge or reason to believe that the Applicant is intending to replace an existing insurance?  □ Yes  □ No

I certify that:
I have accurately recorded the information supplied by the Applicant; and I have given an outline of coverage for the policy applied for to the applicant.

Agent’s Signature: ___________________________ Date: ___________________________

Agent’s Printed Name: ___________________________

Agent Email Address: ___________________________

Agent License Number: ___________________________
**HIPAA & MIB AUTHORIZATION & ACKNOWLEDGEMENT**

**THE ORDER OF UNITED COMMERCIAL TRAVELERS OF AMERICA**

I understand the information obtained by use of the Authorization will be used by The Order of United Commercial Travelers of America to determine eligibility for insurance or for benefits under an existing policy. Any information obtained will not be released by The Order of United Commercial Travelers of America to any person or organization EXCEPT to reinsurance companies, the Medical Information Bureau Inc. (MIB), or other persons or organizations performing business or legal services in connection with my application, claims, including legal proceedings thereon, or as may be otherwise lawfully required or as I may authorize.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, other medically-related facility, insurance or reinsuring company, the Medical Information Bureau or other organization, institution, or person, that has my records or knowledge of my health or prescription drug usage, to disclose to The Order of United Commercial Travelers of America or its reinsurer(s) any such information. A photocopy of this authorization shall be as valid as the original.

I understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. I understand that I may revoke this Authorization, except to the extent that any care provider or The Order of United Commercial Travelers of America has acted in reliance upon this Authorization. My revocation must be submitted in writing to: The Order of United Commercial Travelers of America, 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619.

I also understand that this authorization shall remain in force for thirty (30) months from the date shown below if used in connection with an application for an insurance policy, an application for reinstatement of an insurance policy, or a request for change in policy benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a policy.

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**Applicant Name**

**Social Security Number**

**Date of Birth**

**Signature of Applicant**

**Date**

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**NOTICE TO APPLICANT**

In making this application for insurance to The Order of United Commercial Travelers of America, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential. The Order of United Commercial Travelers of America, or its reinsurer, may; however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health coverage, or a claim for benefits is submitted to such company, the Bureau, 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 the 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 office is 50 Braintree Hill Park, Braintree, Massachusetts 02184-8734.

The Order of United Commercial Travelers of America, or its reinsurer, may also release information from its file to other insurance companies to whom you 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.
## AUTHORITY TO HONOR PREMIUM CHECKS

| IN FAVOR OF: | The Order of United Commercial Travelers of America  
|             | 1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619 |
| Name of Bank Customer: | Type of Account:  
| Insured’s Name: | Checking  
| Routing Number: | Savings  
| To (Name of Bank): | Account Number: |

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Order of United Commercial Travelers of America indicated above, on my account by and payable to the order of The Order of United Commercial Travelers of America for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Order of United Commercial Travelers of America shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Order of United Commercial Travelers of America. I further agree that if any such checks or other orders drawn by The Order of United Commercial Travelers of America be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

| Date: | Signature of Bank Customer: |

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

To: Bank above: In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our Order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

**ATTACH VOIDED CHECK HERE – Deposit Slips NOT Accepted**
Application for Membership

The Order of United Commercial Travelers of America • A Fraternal Benefit Society
1801 Watermark Drive, Suite 100, P.O. Box 159019, Columbus, Ohio 43215-8619
Tel: 614.487.9680 • Toll-free: 800.848.0123 • Fax: 800.948.1039 • www.uct.org
Canadian Office: 901 Centre Street North, Room 300, Calgary, AB T2E 2P6
Tel: 403.277.0745 • Toll-free: 800.267-2371 • Fax: 403.277.6662

Proposed Member Information

Name of council applicant will belong to: ___________________________ Council No.: ______________
Council City: ___________________________________________ State/Prov.: ______________
Applicant Name, First: ___________________________ Mi: ___ Last: ___________________________
Address: ___________________________________________ City: __________ State/Prov.: _______ Postal Code: __________
Home Tel.: (_________) ___________________________ Bus. Tel.: (_________) ___________________________
Birthday: Month “ ” Day “ ” Year Social Security No./Social Insurance No.: ___________________________
Email Address: ___________________________________________ Sex: ☐ Male ☐ Female

Is applicant currently insured with UCT? ☐ Yes ☐ No
Has applicant ever been a member of UCT? ☐ Yes ☐ No ☐ If “Yes,” list member No.: ___________________________
Is applicant’s spouse a member of UCT? ☐ Yes ☐ No ☐ If “Yes,” list member No.: ___________________________

Member Dues Collected (check one)

☐ Member Dues – when purchasing insurance ..............................................................................$30 minimum
☐ Fraternal Membership – no insurance purchased ($12 + $18 minimum Member Dues).................................$30 minimum

Please enroll me for membership in UCT. I understand UCT is a fraternal benefit society and agree to abide by the Society’s Constitution and Bylaws.

Applicant’s Signature: X ___________________________ Date: ___________________________

For Completion by Sponsoring Member/Agent

This is to certify that I am acquainted with the applicant and hereby recommend the applicant for membership.

Sponsoring Member/Agent’s Name (Please Print): ___________________________________________
Address: ___________________________________________ City: __________ State/Prov.: _______ Postal Code: __________
Sponsoring Member/Agent No.: __________________________________________________________
Sponsoring Member/Agent’s Signature: X ___________________________ Date: ___________________________

For Completion by Council Secretary if Necessary

Council Action: ☐ Approved ☐ Disapproved
Secretary’s Signature: ______________________________________________ Date: ___________________________

M-81 Rev. 0813

Rev. 8/13 Page 14
IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ................................................................. □ YES □ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ................................................................. □ YES □ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

<table>
<thead>
<tr>
<th>INSURER NAME</th>
<th>CONTRACT OR POLICY NUMBER</th>
<th>INSURED OR ANNUITANT</th>
<th>REPLACED (R) OR FINANCING (F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
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</tr>
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<td></td>
<td></td>
</tr>
<tr>
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Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

...................................................................................................................................................................................

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name

Date

Producer's Signature and Printed Name

Date
I do not want this notice read aloud to me. ________ (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable? Could they change? You're older—are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid, you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy? Is this a tax free exchange? (See your tax advisor.) Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
IMPORTANT NOTICE:
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What are the tax consequences of buying the new policy? Is this a tax free exchange? (See your tax advisor.) Is there a benefit from favorable "grandfathered' treatment of the old policy under the federal tax code?
### Accelerated Death Benefit Rider Disclosure Statement

**CONSEQUENCES OF THIS BENEFIT** – Receipt of the Accelerated Death Benefit will reduce the death benefit of your term policy.

| Medical Condition allowing the Accelerated Death Benefit | An Accelerated Death Benefit is a benefit that allows you, the policyowner, to be advanced a portion of the death benefit of your term life insurance policy if the Insured is diagnosed with a terminal illness after the policy effective date. *Terminal Illness* means a medical condition which is reasonably expected to result in the Insured's death within 12 months or less.

This disclosure form highlights some of the information in the Accelerated Death Benefit rider form. This form is not an insurance contract. If there are any inconsistencies between this disclosure form and the rider, then the terms and conditions of the rider will control.

| Benefit Amount | The amount of the Accelerated Death Benefit will be [25%] of the policy face amount. The Accelerated Death Benefit amount payable to you is reduced:

- first by any due but unpaid premiums on your policy
- by an interest charge for a time period of one year using an interest rate no more than the greater of: (a) the current yield on 90-day treasury bills; or (b) the current maximum statutory adjustable policy loan interest rate
- by an administrative fee not more than $250 to process the claim under this rider.

| To File a Claim | The Accelerated Death Benefit will be paid to you during the Insured's lifetime while the policy is in force, upon receipt of all of the following:

- a completed Accelerated Death Benefit request form; and
- proof that the Insured has been diagnosed with a terminal illness. Such proof will include a signed statement from a licensed physician; and
- written consent of any irrevocable beneficiary or any assignee, if applicable, agreeing that the owner may elect the death benefit advance.

| Benefit Payment | We will pay the Accelerated Death Benefit in a lump sum. Upon payment of the Accelerated Death Benefit, the face amount of the policy will be reduced by the amount of the Accelerated Death Benefit (before any deductions). Also, no further premium payments will be due on your policy. |
Example to show results of exercising the Accelerated Death Benefit on a $100,000 policy

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Death Benefit of policy before Accelerated Death Benefit is paid</td>
<td>$100,000</td>
</tr>
<tr>
<td>2.</td>
<td>Accelerated Death Benefit calculation:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accelerated Death Benefit amount ([25%])</td>
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</tr>
<tr>
<td></td>
<td>Less adjustments:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• any due but unpaid premiums on the policy</td>
<td>($0)</td>
</tr>
<tr>
<td></td>
<td>• an administrative fee (assume $250)</td>
<td>($250)</td>
</tr>
<tr>
<td></td>
<td>• an interest charge (assume 6% interest rate)</td>
<td>($1,500)</td>
</tr>
<tr>
<td></td>
<td>Amount paid to you</td>
<td>$23,250</td>
</tr>
<tr>
<td>3.</td>
<td>Death Benefit of policy after Accelerated Death Benefit is paid</td>
<td>$75,000</td>
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**TAX CONSEQUENCES** - It is possible that part, or all, of the Accelerated Death Benefit may be considered taxable by the Internal Revenue Service. In addition, receipt of this benefit may adversely affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your attorney, accountant or professional tax advisor before requesting this benefit.

Signature of Policyowner

Signature of Agent

Date signed (MM/DD/YYYY)

Policyowner Social Security Number
Accelerated Death Benefit Rider Disclosure Statement

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---

**Signature of Policyowner**

**Signature of Agent**

**Date signed (MM/DD/YYYY)**

**Policyowner Social Security Number**
FOR AGENT USE ONLY

**Term Life Insurance Application Submission Checklist:**

☐ Complete Application

☐ *Life Insurance Buyer’s Guide* – provide copy to applicant (state specific version may apply)

☐ Complete Application for Membership (M-81 Rev. 0813)

☐ Complete Replacement Notice if applicable – leave a copy with the applicant

☐ Accelerated Death Benefit Rider Disclosure Statement – leave second copy with the applicant

☐ Provide client with MIB Notice to Applicant

☐ Provide client with Premium Receipt

---

**PREMIUM RECEIPT**

Make check payable to UCT.

Received from ____________________________, the sum of $__________________.

If, for any reason, the policy is not issued, payment will be refunded in full in a timely manner. Insurance is not effective until the application is approved, the premium has been paid and the policy is issued.

Date: __________________ Licensed Resident Agent: __________________________

All premium checks must be made payable to The Order of United Commercial Travelers of America. Do not make check payable to the agent or leave the payee blank.
Term Life Premium Calculator

Term Life Premium Calculator (agent access section of the UCT website: http://www.uct.org/term_life_calculator.html)

<table>
<thead>
<tr>
<th>Benefit Amount Choose: $25,000 to $250,000* (enter below)</th>
<th>Annual Premium Per $1,000 based on Sex, Age and Tobacco Use (see rate chart for premium and enter below)</th>
<th>Accidental Death Benefit Rider OPTIONAL (see rate chart for premium and enter below)</th>
<th>Waiver of Premium Rider OPTIONAL OR Enter 0 if not taking Rider</th>
<th>Total Annual Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Premium</th>
<th>Semi-Annual</th>
<th>Quarterly</th>
<th>Monthly (EFT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Policy Fee</td>
<td>$50.00</td>
<td>$25.00</td>
<td>$12.50</td>
</tr>
<tr>
<td>Balance Total Due</td>
<td>$50.00</td>
<td>$25.00</td>
<td>$12.50</td>
</tr>
</tbody>
</table>

* Higher amounts are available on a case-by-case basis. Contact Agent Services for Details.

Minimum Issue Limits
- Age 18-30: $75,000
- Age 31-40: $50,000
- Age 45-50: $35,000
- Age 51-65: $25,000