



Mutual of Omaha / United of Omaha / United World Contracting Application

To become contracted with one of the above companies, complete the attached application and sign where indicated. Fax or email your completed application along with copies of all insurance licenses for the states in which you will be soliciting business.

If you require any assistance, please call us at 1 561 948 6074.

Please fax or email pages back to us that you have written on. Include your state insurance license(s), declaration page of your E and O insurance and void check.

E and O is not required if you are selling Medicare supplement only.

This company offers a full line of annuity, long term care and life insurance products which require E and O.

Sincerely,
Agent Services (www.naaip.org/agents)

Fax: 1-866-436-1640
Email: bob@naaip.org



General Agent Contract Checklist

Individual/Entity Name: _____

REQUIRED DOCUMENTS FOR CONTRACTING

- General Agent Agreement – Return Signature Page Only**
 - Signature Page Signed & Dated
 - Full Name Printed or Typed
 - Tax Identification Number Section Completed
 - Certification Section Completed, Signed & Dated

- Background & Information Sheet**
 - Personal Section Completed
 - Business Section Completed
 - Errors & Omissions Information Completed
 - Background Experience Questions 1 and 2 Answered
 - Answering “YES” to either question requires a written, signed and dated explanation.
 - Signed & Dated

- Fair Credit Reporting Act Disclosure**
 - Signed & Dated

- Direct Deposit Authorization**
 - Completed, Signed & Dated
 - Voided Check or Deposit Slip Attached

- Current State Licenses**
 - ALL States in Which General Agent Will Be Soliciting Business
NOTE: For contracted entities who will not sell, solicit, negotiate or hold themselves out as an insurance agency, no license is required except in the following states:
 - Corporations: GA, MA, MT, NM, PA, UT, VA
 - Individuals: GA, KS, MA, MT, NM, PA, UT, VA

- Long Term Care Training Certificate (Required if contracting to sell Long Term Care)**
 - If contracting to sell Long Term Care products in states that have Partnership or Producer Training Requirements, agent must complete their resident state’s initial and refresher training requirements **before soliciting** any Long Term Care policies.
 - Provide a copy of the initial training certificate **AND**
 - Refresher training certificate (if applicable)

- Anti-Money Laundering Certification (if applicable**)**
**If new producer-certification must be completed after production number is assigned and Sales Professional Access logon is granted.

- Florida Counties (if applicable***)**
***The state of Florida requires that *non-resident producers physically soliciting* business in FL must also hold appointments in each of those counties. Please mark one of the following:
 - Producer will not be physically soliciting in Florida **OR**
 - Producer will be physically soliciting in the following Florida Counties _____

PLEASE NOTE

ALL MATERIALS MUST BE RETURNED TO YOUR MASTER GENERAL AGENCY TO CONTINUE THE CONTRACTING PROCESS

Master General Agency: Transmittal Form(s) must accompany all General Agent contracting paperwork.



**TO BE COMPLETED BY GENERAL AGENT
 FOR ALL STATES EXCEPT NEW YORK**

GENERAL AGENT

By: _____
(Signature always required)

Printed Name: _____
(Same as signature above)

Title: _____

General Agent: _____
(As it appears on license)

DBA: _____
(If applicable)

Date: _____

Designated Beneficiary _____



Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number. For other entities, it is your employer identification number.

Social Security Number

			+		+				
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or

Employer Identification Number

	+								
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Certification

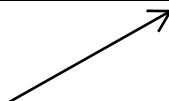
Under penalties of perjury, I certify that:

1. The number provided is my correct taxpayer identification number, **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (a U.S. citizen or U.S. resident alien or a partnership, corporation, company or association created or organized in the U.S. or under the laws of the U.S. or an estate (other than a foreign estate) or a domestic trust (as defined in Regulations section 301.7701-7)).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

The Internal Revenue Service does not require your consent to any provision of this document other than the above-referenced certifications required to avoid backup withholding.

Sign Here	Signature of U.S. person →	Date →
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**TO BE COMPLETED BY GENERAL AGENT
FOR NEW YORK ONLY**



GENERAL AGENT

By: _____
(Signature always required)

Printed Name: _____
(Same as signature above)

Title: _____

General Agent: _____
(As it appears on license)

DBA: _____
(If applicable)

Date: _____

Designated Beneficiary _____



Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number. For other entities, it is your employer identification number.

Social Security Number

			+		+				
--	--	--	---	--	---	--	--	--	--

or

Employer Identification Number

		+							
--	--	---	--	--	--	--	--	--	--

Certification

Under penalties of perjury, I certify that:

1. The number provided is my correct taxpayer identification number, **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (a U.S. citizen or U.S. resident alien or a partnership, corporation, company or association created or organized in the U.S. or under the laws of the U.S. or an estate (other than a foreign estate) or a domestic trust (as defined in Regulations section 301.7701-7)).

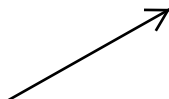
Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

The Internal Revenue Service does not require your consent to any provision of this document other than the above-referenced certifications required to avoid backup withholding.

Sign Here

Signature of U.S. person →

Date →



MUTUAL OF OMAHA INSURANCE COMPANY
UNITED OF OMAHA LIFE INSURANCE COMPANY
UNITED WORLD LIFE INSURANCE COMPANY
OMAHA LIFE INSURANCE COMPANY
OMAHA INSURANCE COMPANY



**TO BE COMPLETED BY SPECIAL AGENT
FOR ALL STATES EXCEPT NEW YORK**



<p>SPECIAL AGENT</p> <p>By: _____ <small>(Signature always required)</small></p> <p>Printed Name: _____ <small>(Same as signature above)</small></p> <p>Special Agent: _____ <small>(As it appears on license)</small></p> <p>Date: _____</p>
--



[Remainder of page intentionally left blank]



**TO BE COMPLETED BY Special Agent
FOR NEW YORK ONLY**



SPECIAL AGENT
By: _____ <small>(Signature always required)</small>
Printed Name: _____ <small>(Same as signature above)</small>
Special Agent: _____ <small>(As it appears on license)</small>
Date: _____



[Remainder of page intentionally left blank]

**MUTUAL OF OMAHA INSURANCE COMPANY AND ITS AFFILIATES
BACKGROUND AND INFORMATION SHEET**

Name: _____

Social Security Number: _____ Date of Birth: _____

Home Address (must be a physical street address): _____

Home Phone: _____

Cell Phone: _____ (optional) E-mail Address: _____ (optional)

Business Name: _____
(if applicable)

Personal Business Address: _____

***Note** – All correspondence (including compensation statements), will be mailed to the personal business address indicated. Only one business address is supported per individual. If no business address is indicated, mail will be directed to home address.

Address for overnight packages (cannot be a P.O. Box): _____

Business Phone: _____ Business Fax: _____

Tax I.D. Number: _____ E-mail Address: _____

Please identify your Master General Agency (if applicable): _____

Errors and Omission Insurance Information:

In accordance with the requirements of Mutual of Omaha and its affiliates, I agree to maintain professional liability insurance (referred to as Errors & Omissions coverage) covering the sales and service of Mutual of Omaha and its affiliates insurance products.

The coverage is with _____
Carrier Name

In the amount of \$ _____

I will promptly notify Mutual of Omaha and its affiliates of any cancellation or major modifications to my coverage.

BACKGROUND EXPERIENCE. Note: Please read each question carefully. Failure to answer "Yes" below, when appropriate, may result in the denial of your request to be contracted.

1. Have you ever been fined, suspended, placed on probation, paid administrative costs, entered into a consent order, been issued a restricted license or otherwise been disciplined or reprimanded, or are you currently under investigation by any insurance department, FINRA (formerly known as the NASD), SEC or any other regulatory authority?
_____ Yes _____ No

2. Have you ever been convicted or plead guilty or nolo contendere (no contest), served any probation, paid any fines or court costs, had charges dismissed through any type of first offender or deferred adjudication or suspended sentence procedure, or are any charges currently pending against you for any offense other than a minor traffic violation?
_____ Yes _____ No

PROVIDE A WRITTEN EXPLANATION AND APPLICABLE SUPPORTING DOCUMENTATION (i.e., court documents, insurance department documents, etc.) FOR ANY QUESTION TO WHICH YOU RESPONDED "YES". Please be sure to date and sign the written statement.



Candidate Signature

Date

FAIR CREDIT REPORTING ACT DISCLOSURE

Mutual of Omaha Insurance Company and its affiliates with which you intend to contract (together, "Mutual of Omaha") will obtain and use consumer reports for the purpose of serving as a factor in establishing your eligibility for contracting as an insurance producer. We will obtain these consumer reports from:

First Advantage Corporation
100 Carillon Parkway, Suite 100
St. Petersburg, FL 33716

"Consumer report" means a written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which will be used by Mutual of Omaha, in whole or in part for the purpose of serving as a factor in establishing your eligibility to be contracted as an insurance producer.

This means a credit report, criminal report and report of insurance department regulatory actions will be obtained and reviewed as part of a background investigation in order to determine your eligibility to be contracted and appointed.

For residents of California, Minnesota and Oklahoma: You have a right to request a copy of the consumer report which will disclose the nature and scope of the report.
 Yes, please provide me a copy of the consumer report

For New York: You have a right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

CANDIDATE'S STATEMENT – READ CAREFULLY

Mutual of Omaha is hereby authorized to obtain and use a consumer report of my criminal record history, insurance department history and credit history through any consumer reporting agency or through inquiries with my past or present employers, neighbors, friends or others with whom I am acquainted. I understand that this consumer report will include information as to my general reputation, personal characteristics and mode of living.

AUTHORIZATION

I authorize any consumer reporting agency, insurance department, law enforcement agency, the Financial Industry Regulatory Authority, The Securities and Exchange Commission or any other person or organization having any consumer report records, data or information concerning my credit history, public record information, insurance license, regulatory action history or criminal record history to furnish such consumer report records, data and information to Mutual of Omaha.

I understand that if contracted, this authorization will remain valid as long as I am contracted with Mutual of Omaha.

A photocopy of this authorization shall be considered as effective as the original.



Candidate Signature

Date

Print Name

**MUTUAL OF OMAHA INSURANCE COMPANY
UNITED OF OMAHA LIFE INSURANCE COMPANY
UNITED WORLD LIFE INSURANCE COMPANY
OMAHA INSURANCE COMPANY
HEALTH ISSUE ADVANCE COMMISSION AMENDMENT**

GENERAL AGENT/REPRESENTATIVE

BY: _____ SOCIAL SECURITY or
TAX ID NUMBER: _____
(Signature always required)

PRINTED NAME: _____

TITLE: _____ DATE: _____

Please Note: The completed Advance Commission Transmittal Form must accompany this signed Advance Commission Amendment.

MASTER GENERAL AGENCY

I approve of the Advance of Commission pursuant to this Agreement.

BY: _____
(Signature always required)

PRINTED NAME: _____

TITLE: _____ DATE: _____

This Amendment is subject to Company's written approval. If Company approves this Amendment, Company will send an executed signature page to the GA/Rep. The executed signature page will become part of this Amendment. The advance mode and the advance maximum amount per policy will be included on the executed signature page.

**UNITED OF OMAHA LIFE INSURANCE COMPANY
LIFE ISSUE ADVANCE COMMISSION AMENDMENT**



GENERAL AGENT/REPRESENTATIVE	
BY: _____	SOCIAL SECURITY or TAX ID NUMBER: _____
(Signature always required)	
PRINTED NAME: _____	
TITLE: _____ DATE: _____	

Please Note: The completed Advance Commission Transmittal Form must accompany this signed Advance Commission Amendment.

MASTER GENERAL AGENCY	
I approve of the Advance of Commission pursuant to this Agreement.	
BY: _____	
(Signature always required)	
PRINTED NAME: _____	
TITLE: _____ DATE: _____	

This Amendment is subject to Company's written approval. If Company approves this Amendment, Company will send an executed signature page to the GA/Rep. The executed signature page will become part of this Amendment. The advance mode and the advance maximum amount per policy will be included on the executed signature page.



Mutual of Omaha Companies Advancing Options

Life products

_____ As Earned

_____ 6 Month Advance

N/A 9 Month Advance

Health Products

_____ As Earned

_____ 6 Month Advance

_____ 9 Month Advance

_____ 12 Month Advance

Agent Name: _____

Agent Signature: _____

