CENTRAL STATES HEALTH & LIFE CO. OF OMAHA

(A Mutual Legal Reserve Company)
P.O. Box 34350, Omaha, Nebraska 68134-0350 • 1-800-826-6587

SCHEDULE / APPLICATION

I.D. No.	BR.	REG.

Certificate No.

Account No.

Primary Borrower (called "You" or "Your")	Date of Birth	Co-Borrower (also called "You" or "Your")	Date of Birth

Address (Street, City, State, Zip)	Address (Street, City, State, Zip)

Creditor Beneficiary (Name & Address)	Secondary Beneficiary (Name & Address)

Effective Date	Scheduled Expiration Date of Insurance	First Payment Due Date	Term of Insurance (Months)	Interest Rate	Term of Loan (Months)

Life Term Coverage	Original Amount of Life Insurance	Life Premium*
Gross Decreasing Life ☐ Single *(01)* ☐ Joint *(03)*	$	$
Level Life ☐ Single *(02)* ☐ Joint *(04)*	$	$
Net Pay + 2 Decreasing Life ☐ Single *(36)* ☐ Joint *(37)*	$	$
Truncated Net Pay +2 Decreasing Life ☐ Single *(39)* ☐ Joint *(40)*	$	$

Amount Financed	Balloon Payment Amount	Scheduled Loan Payment
$	$	$

Disability Coverage	Maximum Monthly Total Disability Benefit	Disability Premium*
☐ Single (Primary Only) ☐ Joint	$	$

Maximum Disability Benefit Payments	☐ -Full Term of Insurance	☐ -36 Months	☐ -24 Months	☐ -12 Months
		(critical period disability only)		

Disability Waiting Period	☐ 14-Day Retroactive	☐ 30-Day Elimination
Home Office Use Only	Single 01, 24, 49, 69	02, 27, 52, 72
	Joint 54, 1J, 1E, 89	57, 1M, 1H, 1C

***If the word NONE or if no amount is shown, that coverage and the provisions which relate to it do not apply to You.**

Your signature below means that You understand and agree that the following statements are offered to the Company as consideration for the insurance applied for on the Effective Date shown above. Any statements or misrepresentations which affect Our acceptance of You may result in loss of coverage.

Part A **ELIGIBILITY REQUIREMENTS—READ AND SIGN PART "A"**

To determine if You are eligible for insurance coverage, the Company requires the following:

1) For any insurance, You have not reached Your 71st birthday as of the Effective Date. Insurance terminates at age 71.
2) **Disability Coverage:** You are gainfully employed (actively working full-time for at least 25 hours a week) as of the Effective Date.
3) You understand that this insurance contains limitations and exclusions as outlined in the certificate.
4) You understand that the purchase of credit insurance is optional and not required to obtain credit approval.

(Schedule / Application signed by Power of Attorney voids protection.)

Signature of Primary Borrower Date

Signature of Co-Borrower Date

Signature and/or Printed Name of Agent (Where required by law)

Part B **EVIDENCE OF INSURABILITY- READ AND SIGN PART "B" IF REQUIRED**

5) **Life Coverage:** During the 12 months prior to the Effective Date of coverage, You have not been diagnosed, treated or been advised to have treatment, or have not been prescribed medications for any condition, disease or disorder of: the heart or circulatory system, stroke; high blood pressure (2 or more prescribed medications); Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); HIV infection; cancer; the kidney; medicated diabetes; the nervous system; the lungs or liver; alcoholism or drug addiction.
6) **Disability Coverage:** During the 12 months prior to the Effective Date of coverage, You have not been diagnosed, treated or been advised to have treatment, or have not been prescribed medications for any condition, disease or disorder of: the heart or circulatory system, stroke; high blood pressure (2 or more prescribed medications); Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); HIV infection; cancer; the kidney; medicated diabetes; the nervous system; the lungs or liver; alcoholism or drug addiction; arthritis; fibromyalgia; carpal tunnel syndrome; the back, spine, neck, bone or joints; or mental disorders.

Your signature below means that You understand and agree with the statements above and contained in Part A and Part B. If You are unable to agree with the statement(s), You may not be eligible for coverage as applied for through this Schedule / Application.

(Schedule / Application signed by Power of Attorney voids protection.)

Signature of Primary Borrower Date

Signature of Co-Borrower Date

Signature and/or Printed Name of Agent (Where required by law)

- **PRE-EXISTING CONDITIONS MAY NOT BE IMMEDIATELY COVERED.**
- **IF YOUR COVERAGE INCLUDES A BALLOON PAYMENT, THE TOTAL ORIGINAL AMOUNT OF LIFE INSURANCE INCLUDES THE GROSS DECREASING LIFE AND LEVEL LIFE ORIGINAL AMOUNTS OF LIFE INSURANCE.**
- **NO DISABILITY COVERAGE PROVIDED ON THE BALLOON PAYMENT.**
- **IN THE EVENT OF PRE-PAYMENT OF YOUR LOAN, REFER TO PART H, REFUNDS.**
- **THIS INSURANCE MAY NOT BE ENOUGH TO: COMPLETELY PAY OFF YOUR LOAN; MAKE YOUR SCHEDULED LOAN PAYMENT; OR LAST THE FULL LENGTH OF YOUR LOAN.**
- **THIS INSURANCE MAY BE LIMITED BY ENDORSEMENT BASED ON THE MAXIMUM LIMITS PROVISION IN PART L, GENERAL PROVISIONS.**

CENTRAL STATES HEALTH & LIFE CO. OF OMAHA

(A Mutual Legal Reserve Company)
P.O. Box 34350, Omaha, Nebraska 68134-0350 • 1-800-826-6587

SCHEDULE / APPLICATION

I.D. No.	BR.	REG.

Certificate No.

Account No.

Primary Borrower (called "You" or "Your")	Date of Birth	Co-Borrower (also called "You" or "Your")	Date of Birth

Address (Street, City, State, Zip)	Address (Street, City, State, Zip)

Creditor Beneficiary (Name & Address)	Secondary Beneficiary (Name & Address)

Effective Date	Scheduled Expiration Date of Insurance	First Payment Due Date	Term of Insurance (Months)	Interest Rate	Term of Loan (Months)

Life Term Coverage	Original Amount of Life Insurance	Life Premium*
Gross Decreasing Life ☐ Single *(01)* ☐ Joint *(03)*	$	$
Level Life ☐ Single *(02)* ☐ Joint *(04)*	$	$
Net Pay + 2 Decreasing Life ☐ Single *(36)* ☐ Joint *(37)*	$	$
Truncated Net Pay +2 Decreasing Life ☐ Single *(39)* ☐ Joint *(40)*	$	$

Amount Financed	Balloon Payment Amount	Scheduled Loan Payment
$	$	$

Disability Coverage	Maximum Monthly Total Disability Benefit	Disability Premium*
☐ Single (Primary Only) ☐ Joint	$	$

Maximum Disability Benefit Payments	☐ Full Term of Insurance	☐ 36 Months	☐ 24 Months	☐ 12 Months
		(critical period disability only)		

Disability Waiting Period	☐ 14-Day Retroactive	☐ 30-Day Elimination
Home Office Use Only	Single 01, 24, 49, 69	02, 27, 52, 72
	Joint 54, 1J, 1E, 89	57, 1M, 1H, 1C

***If the word NONE or if no amount is shown, that coverage and the provisions which relate to it do not apply to You.**

Your signature below means that You understand and agree that the following statements are offered to the Company as consideration for the insurance applied for on the Effective Date shown above. Any statements or misrepresentations which affect Our acceptance of You may result in loss of coverage.

Part A **ELIGIBILITY REQUIREMENTS—READ AND SIGN PART "A"**

To determine if You are eligible for insurance coverage, the Company requires the following:

1) For any insurance, You have not reached Your 71st birthday as of the Effective Date. Insurance terminates at age 71.
2) **Disability Coverage:** You are gainfully employed (actively working full-time for at least 25 hours a week) as of the Effective Date.
3) You understand that this insurance contains limitations and exclusions as outlined in the certificate.
4) You understand that the purchase of credit insurance is optional and not required to obtain credit approval.

(Schedule / Application signed by Power of Attorney voids protection.)

Signature of Primary Borrower Date

Signature of Co-Borrower Date

Signature and/or Printed Name of Agent (Where required by law)

Part B **EVIDENCE OF INSURABILITY- READ AND SIGN PART "B" IF REQUIRED**

5) **Life Coverage:** During the 12 months prior to the Effective Date of coverage, You have not been diagnosed, treated or been advised to have treatment, or have not been prescribed medications for any condition, disease or disorder of: the heart or circulatory system, stroke; high blood pressure (2 or more prescribed medications); Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); HIV infection; cancer; the kidney; medicated diabetes; the nervous system; the lungs or liver; alcoholism or drug addiction.
6) **Disability Coverage:** During the 12 months prior to the Effective Date of coverage, You have not been diagnosed, treated or been advised to have treatment, or have not been prescribed medications for any condition, disease or disorder of: the heart or circulatory system, stroke; high blood pressure (2 or more prescribed medications); Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); HIV infection; cancer; the kidney; medicated diabetes; the nervous system; the lungs or liver; alcoholism or drug addiction; arthritis; fibromyalgia; carpal tunnel syndrome; the back, spine, neck, bone or joints; or mental disorders.

Your signature below means that You understand and agree with the statements above and contained in Part A and Part B. If You are unable to agree with the statement(s), You may not be eligible for coverage as applied for through this Schedule / Application.

(Schedule / Application signed by Power of Attorney voids protection.)

Signature of Primary Borrower Date

Signature of Co-Borrower Date

Signature and/or Printed Name of Agent (Where required by law)

- **PRE-EXISTING CONDITIONS MAY NOT BE IMMEDIATELY COVERED.**
- **IF YOUR COVERAGE INCLUDES A BALLOON PAYMENT, THE TOTAL ORIGINAL AMOUNT OF LIFE INSURANCE INCLUDES THE GROSS DECREASING LIFE AND LEVEL LIFE ORIGINAL AMOUNTS OF LIFE INSURANCE.**
- **NO DISABILITY COVERAGE PROVIDED ON THE BALLOON PAYMENT.**
- **IN THE EVENT OF PRE-PAYMENT OF YOUR LOAN, REFER TO PART H, REFUNDS.**
- **THIS INSURANCE MAY NOT BE ENOUGH TO: COMPLETELY PAY OFF YOUR LOAN; MAKE YOUR SCHEDULED LOAN PAYMENT; OR LAST THE FULL LENGTH OF YOUR LOAN.**
- **THIS INSURANCE MAY BE LIMITED BY ENDORSEMENT BASED ON THE MAXIMUM LIMITS PROVISION IN PART L, GENERAL PROVISIONS.**

CENTRAL STATES HEALTH & LIFE CO. OF OMAHA

(A Mutual Legal Reserve Company)
P.O. Box 34350, Omaha, Nebraska 68134-0350 • 1-800-826-6587

SCHEDULE

I.D. No.	BR.	REG.

Certificate No.

Account No.

Primary Borrower (called "You" or "Your")	Date of Birth	Co-Borrower (also called "You" or "Your")	Date of Birth

Address (Street, City, State, Zip)	Address (Street, City, State, Zip)

Creditor Beneficiary (Name & Address)	Secondary Beneficiary (Name & Address)

Effective Date	Scheduled Expiration Date of Insurance	First Payment Due Date	Term of Insurance (Months)	Interest Rate	Term of Loan (Months)

Life Term Coverage	Original Amount of Life Insurance	Life Premium*
Gross Decreasing Life ☐ Single *(01)* ☐ Joint *(03)*	$	$
Level Life ☐ Single *(02)* ☐ Joint *(04)*	$	$
Net Pay + 2 Decreasing Life ☐ Single *(36)* ☐ Joint *(37)*	$	$
Truncated Net Pay +2 Decreasing Life ☐ Single *(39)* ☐ Joint *(40)*	$	$

Amount Financed	Balloon Payment Amount	Scheduled Loan Payment
$	$	$

Disability Coverage	Maximum Monthly Total Disability Benefit	Disability Premium*
☐ Single (Primary Only) ☐ Joint	$	$

Maximum Disability Benefit Payments	☐ Full Term of Insurance	☐ 36 Months	☐ 24 Months	☐ 12 Months
		(critical period disability only)		

Disability Waiting Period	☐ 14-Day Retroactive	☐ 30-Day Elimination
Home Office Use Only	Single 01, 24, 49, 69	02, 27, 52, 72
	Joint 54, 1J, 1E, 89	57, 1M, 1H, 1C

CANCELLATION RECEIPT

	YR.	MO.	DAY
Date of Cancellation			
Date of Certificate			
Time in Force			

	ORIGINAL PREMIUM	REFUND %	PREMIUM REFUNDED
LIFE	$		
DISABILITY	$		
TOTAL	$		

ROUNDED TO _____ WHOLE MONTHS Refund Table: ☐ Rule of 78 ☐ Pro Rata ☐ _____

This certificate is cancelled as of twelve o'clock midnight, Standard Time, on the date listed above, due to one of the following reasons:

☐ Customer Request (loan still active) ☐ Loan Paid Off ☐ Renewal/Refinance ☐ Repossession (loan charge off)

If the cancellation of this certificate is for reasons other than those listed above, a signature of the Primary Borrower is required below.

I hereby request cancellation of this certificate and acknowledge that any premium refund due as a result of this early cancellation has been refunded or credited to my account.

_____ Signature of Primary Borrower

_____ Date

CENTRAL STATES HEALTH & LIFE CO. OF OMAHA

(A Mutual Legal Reserve Company)
P.O. Box 34350, Omaha, Nebraska 68134-0350 • 1-800-826-6587

SCHEDULE / APPLICATION

I.D. No.	BR.	REG.

Certificate No.

Account No.

Primary Borrower (called "You" or "Your")	Date of Birth	Co-Borrower (also called "You" or "Your")	Date of Birth

Address (Street, City, State, Zip)	Address (Street, City, State, Zip)

Creditor Beneficiary (Name & Address)	Secondary Beneficiary (Name & Address)

Effective Date	Scheduled Expiration Date of Insurance	First Payment Due Date	Term of Insurance (Months)	Interest Rate	Term of Loan (Months)

Life Term Coverage	Original Amount of Life Insurance	Life Premium*
Gross Decreasing Life ☐ Single *(01)* ☐ Joint *(03)*	$	$
Level Life ☐ Single *(02)* ☐ Joint *(04)*	$	$
Net Pay + 2 Decreasing Life ☐ Single *(36)* ☐ Joint *(37)*	$	$
Truncated Net Pay +2 Decreasing Life ☐ Single *(39)* ☐ Joint *(40)*	$	$

Amount Financed	Balloon Payment Amount	Scheduled Loan Payment
$	$	$

Disability Coverage	Maximum Monthly Total Disability Benefit	Disability Premium*
☐ Single (Primary Only) ☐ Joint	$	$

Maximum Disability Benefit Payments	☐ -Full Term of Insurance	☐ -36 Months	☐ -24 Months	☐ -12 Months
		(critical period disability only)		

Disability Waiting Period	☐ 14-Day Retroactive	☐ 30-Day Elimination
Home Office Use Only	Single 01, 24, 49, 69	02, 27, 52, 72
	Joint 54, 1J, 1E, 89	57, 1M, 1H, 1C

***If the word NONE or if no amount is shown, that coverage and the provisions which relate to it do not apply to You.**

Your signature below means that You understand and agree that the following statements are offered to the Company as consideration for the insurance applied for on the Effective Date shown above. Any statements or misrepresentations which affect Our acceptance of You may result in loss of coverage.

Part A **ELIGIBILITY REQUIREMENTS—READ AND SIGN PART "A"**

To determine if You are eligible for insurance coverage, the Company requires the following:

1) For any insurance, You have not reached Your 71st birthday as of the Effective Date. Insurance terminates at age 71.
2) **Disability Coverage:** You are gainfully employed (actively working full-time for at least 25 hours a week) as of the Effective Date.
3) You understand that this insurance contains limitations and exclusions as outlined in the certificate.
4) You understand that the purchase of credit insurance is optional and not required to obtain credit approval.

(Schedule / Application signed by Power of Attorney voids protection.)

Signature of Primary Borrower Date

Signature of Co-Borrower Date

Signature and/or Printed Name of Agent (Where required by law)

Part B **EVIDENCE OF INSURABILITY- READ AND SIGN PART "B" IF REQUIRED**

5) **Life Coverage:** During the 12 months prior to the Effective Date of coverage, You have not been diagnosed, treated or been advised to have treatment, or have not been prescribed medications for any condition, disease or disorder of: the heart or circulatory system, stroke; high blood pressure (2 or more prescribed medications); Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); HIV infection; cancer; the kidney; medicated diabetes; the nervous system; the lungs or liver; alcoholism or drug addiction.
6) **Disability Coverage:** During the 12 months prior to the Effective Date of coverage, You have not been diagnosed, treated or been advised to have treatment, or have not been prescribed medications for any condition, disease or disorder of: the heart or circulatory system, stroke; high blood pressure (2 or more prescribed medications); Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); HIV infection; cancer; the kidney; medicated diabetes; the nervous system; the lungs or liver; alcoholism or drug addiction; arthritis; fibromyalgia; carpal tunnel syndrome; the back, spine, neck, bone or joints; or mental disorders.

Your signature below means that You understand and agree with the statements above and contained in Part A and Part B. If You are unable to agree with the statement(s), You may not be eligible for coverage as applied for through this Schedule / Application.

(Schedule / Application signed by Power of Attorney voids protection.)

Signature of Primary Borrower Date

Signature of Co-Borrower Date

Signature and/or Printed Name of Agent (Where required by law)

- **PRE-EXISTING CONDITIONS MAY NOT BE IMMEDIATELY COVERED.**
- **IF YOUR COVERAGE INCLUDES A BALLOON PAYMENT, THE TOTAL ORIGINAL AMOUNT OF LIFE INSURANCE INCLUDES THE GROSS DECREASING LIFE AND LEVEL LIFE ORIGINAL AMOUNTS OF LIFE INSURANCE.**
- **NO DISABILITY COVERAGE PROVIDED ON THE BALLOON PAYMENT.**
- **IN THE EVENT OF PRE-PAYMENT OF YOUR LOAN, REFER TO PART H, REFUNDS.**
- **THIS INSURANCE MAY NOT BE ENOUGH TO: COMPLETELY PAY OFF YOUR LOAN; MAKE YOUR SCHEDULED LOAN PAYMENT; OR LAST THE FULL LENGTH OF YOUR LOAN.**
- **THIS INSURANCE MAY BE LIMITED BY ENDORSEMENT BASED ON THE MAXIMUM LIMITS PROVISION IN PART L, GENERAL PROVISIONS.**

CREDIT LIFE AND DISABILITY CERTIFICATE

—TABLE OF CONTENTS—

PART A **FREE LOOK – PLEASE READ**

Please read this certificate. If You are not satisfied, send it back to the Creditor within 30 days after You receive it. Any premium You paid will be refunded or credited to Your account. The refund or credit will not include any interest charges incurred during this time. That will mean coverage was never in force.

PART B **WHAT YOU GET**

We certify that if We have been paid the premium shown in the Schedule / Application, You are insured for the coverage shown in the Schedule / Application, subject to the terms of the Group Master Policy, certificate of insurance and any endorsement(s).

PART C **WHO GETS PAID**

Claim payments are made to the irrevocable Creditor Beneficiary named in the Schedule / Application to pay off or reduce Your debt. If claim payments are more than the balance of Your debt, the difference will be paid to You or to the Secondary Beneficiary named in the Schedule / Application, other than the Creditor, if any, or to Your estate.

PART D **DEFINITIONS**

"Balloon Payment Amount" means the final lump sum payment due at the end of Your loan as defined in Your loan documents.

"Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any lender, vendor or lessor. The Creditor is specified in the Schedule / Application as the Creditor Beneficiary.

"Disability Waiting Period" means the length of time a borrower must be totally disabled before Total Disability benefits become payable. The Disability Waiting Period must occur while this certificate is in force. In connection with a retroactive waiting period, Total Disability benefits are calculated from the first day of the Disability Waiting Period once it has been met. In connection with an elimination waiting period, Total Disability benefits are calculated from the day after the Disability Waiting Period ends.

"Period of Total Disability" means the period of time that You are considered unable to work due to a Total Disability as defined in Part D – Definitions of Your certificate. A Period of Total Disability begins on the first day You receive medical treatment and are deemed unable to work due to Total Disability, subject to any limitations. It ends on the date You are able or released to return to work. You could have more than one injury or sickness during the same Period of Total Disability. Only one monthly Total Disability benefit is payable under this certificate at a time.

If within 30 days after You return to work You become totally disabled again due to the same or related causes, the Period of Total Disability will be treated as a continuation of the earlier period. After You return to work and become totally disabled due to a new or unrelated condition, a new Period of Total Disability will begin and a new Disability Waiting Period will apply.

"Total Disability" means, during the first 12 consecutive months of Total Disability, that as the result of sickness or injury You: (1) are receiving regular medical treatment for the cause of disability; and, (2) are unable to perform the major duties of Your occupation or profession. After the first 12 consecutive months of Total Disability, the definition changes and requires that You: (1) are receiving regular medical treatment for the cause of disability; and, (2) are not able to perform the important duties of any occupation for which You are reasonably qualified by education, training or experience. You will be required to give Us written proof of Your continuing Total Disability from time to time.

"We", "Us" or "Our" means Central States Health & Life Co. of Omaha.

"You" or "Your" means the Primary Borrower or Co-Borrower, as listed in the Schedule / Application.

PART E **WHAT WE WILL PAY**

Single Life Insurance Benefit: If You (the Primary Borrower as shown in the Schedule / Application), die while insured for single life coverage, We will pay the amount of life insurance in force at the time of death after We receive proof of death.

Joint Life Insurance Benefit: If You or Your Co-Borrower die while insured for joint life coverage, We will pay the amount of life insurance in force at the time of death after We receive proof of death. Only one death benefit is payable under this certificate.

Amount of Life Insurance: The amount of life insurance depends on the type of life insurance plan selected when You applied for this certificate. The plan selected is shown in the Schedule / Application. Under any of the plans, the amount of life insurance will not exceed the Original Amount of Life Insurance shown in the Schedule / Application. The amount of insurance is determined as follows, subject to any provisions, limitations or exclusions of the certificate:

Gross Decreasing Life: The amount of decreasing life insurance is the Original Amount of Life Insurance shown in the Schedule / Application until the First Payment Due Date; and includes the principal, fees, premium amounts and interest. The amount of decreasing life insurance then decreases each month by an equal amount (the decreasing amount). That amount is the Original Amount of Life Insurance divided by the number of months in the Term of Insurance shown in the Schedule / Application. The amount of life insurance in force is calculated by multiplying the decreasing amount times the remaining term of insurance as of the date of death. If the total of payments of Your loan is greater than the total Original Amount of Life Insurance, You have partial coverage and the insurance may not be enough to completely pay off Your loan. If the Term of Insurance is less than the Term of Loan, insurance coverage may not last the full length of Your loan. Only one Gross Decreasing Life benefit is payable under this certificate.

Level Life: The amount of Level Life insurance is the Original Amount of Life Insurance shown in the Schedule / Application. This amount stays the same while this certificate is in effect. If the total of payments of Your loan is greater than the total Original Amount of Life Insurance, You have partial coverage and the insurance may not be enough to completely pay off Your loan. If the Term of Insurance is less than the Term of Loan, insurance coverage may not last the full length of Your loan. Only one Level Life benefit is payable under this certificate.

Net Pay +2 Decreasing Life: The amount of decreasing life insurance is the Original Amount of Life Insurance shown in the Schedule / Application until the First Payment Due Date; and includes the principal, fees and premium amounts. The amount of decreasing life insurance then decreases at the same rate the Amount Financed amortizes over the Term of Loan. The amount of life insurance in force is then calculated by taking the amortized balance of the Original Amount of Life Insurance due upon the date of death plus two month's simple interest on such amount. The amount of life insurance does not include any delinquent payments or unearned interest. If the Amount Financed is greater than the total Original Amount of Life Insurance, You have partial coverage and the insurance may not be enough to completely pay off Your loan. If the Term of Insurance is less than the Term of Loan, insurance coverage may not last the full length of Your loan. Only one Net Pay +2 Decreasing Life benefit is payable under this certificate.

Truncated Net Pay +2 Decreasing Life: The amount of decreasing life insurance is the Original Amount of Life Insurance shown in the Schedule / Application until the First Payment Due Date; and includes the principal, fees and premium amounts. The amount of decreasing life insurance then decreases at the same rate the Amount Financed amortizes over the Term of Loan. The amount of life insurance in force is then calculated by taking the amortized balance of the Original Amount of Life Insurance due upon the date of death plus two month's simple interest on such amount. The amount of life insurance does not include any delinquent payments or unearned interest. If the Amount Financed is greater than the total Original Amount of Life Insurance, You have partial coverage and the insurance may not be enough to completely pay off Your loan. The Term of Insurance is less than the Term of Loan; insurance coverage may not last the full length of Your loan. Only one Truncated Net Pay +2 Decreasing Life benefit is payable under this certificate.

Single Total Disability Insurance Benefit: If You are insured for single Total Disability insurance (must be the Primary Borrower as shown in the Schedule / Application), We will pay the Maximum Monthly Total Disability Benefit shown in the Schedule / Application for each full month of Total Disability. For any Period of Total Disability less than one month, We will pay 1/30th of the Maximum Monthly Total Disability Benefit for each day of disability. You must file proof that You became totally disabled while insured.

Joint Total Disability Insurance Benefit: If You and Your Co-Borrower are insured for joint Total Disability insurance, We will pay the Maximum Monthly Total Disability Benefit shown in the Schedule / Application for each full month of Total Disability. For any Period of Total Disability less than one month, We will pay 1/30th of the Maximum Monthly Total Disability Benefit for each day of disability. You must file proof that You became totally disabled while insured. Only one monthly Total Disability benefit is payable under this certificate at a time.

Amount of Total Disability Insurance Benefit: The Maximum Monthly Total Disability Benefit for each Period of Total Disability will become payable after the Disability Waiting Period indicated in the Schedule / Application. It stops on the earliest of the date: (1) when You are no longer totally disabled; (2) when We have paid the Maximum Monthly Total Disability Benefit for the number of Maximum Disability Benefit Payments as selected in the Schedule / Application, during the Term of Insurance; (3) when You die; or (4) when this insurance stops, whichever comes first. If the Scheduled Loan Payment is greater than the Maximum Monthly Total Disability Benefit, You have partial coverage and You will be obligated to pay the difference. The amount of insurance is determined as follows, subject to any provisions, limitations or exclusions of the certificate:

Full Term of Insurance: If You selected this option, disability coverage will last the full Term of Insurance. If the Term of Insurance is less than the Term of Loan, insurance coverage may not last the full length of Your loan.

Critical Period Disability: If You selected this option, the number of Maximum Disability Benefit Payments payable during the Term of Insurance is shown in the Schedule / Application. The maximum number of payments is an accumulation of payments from all disability claims paid under this certificate. The benefit payments may not last the full Term of Insurance and, may not be enough to completely pay off Your loan. If the Term of Insurance is less than the Term of Loan, insurance coverage may not last the full length of Your loan.

Balloon Payment Amount: Disability benefits are NOT provided for the final balloon payment.

PART F WHAT WE WILL NOT PAY

Misstated Age: If Your Date of Birth was misstated on the Schedule / Application and insurance would not have been issued at Your correct age, any premium You paid will be refunded or credited to Your account when We discover this and benefits will not be paid. If You applied for joint coverage, the difference between the single and joint premium will be refunded or credited and coverage will continue for the remaining insured. The refund or credit amount will not include any interest charges incurred.

Suicide: We will not pay any life claim if You or Your Co-Borrower commit suicide within 12 months of the Effective Date shown in the Schedule / Application. We will refund or credit any Life Premium. If You applied for joint coverage, the difference between the single and joint premium will be refunded or credited and coverage will continue for the remaining insured. The refund or credit amount will not include any interest charges incurred.

Total Disabilities Not Covered: We will not pay the claim or refund the premium if Your disability:

1. is a result of normal pregnancy or childbirth,
2. is a result of an intentionally self-inflicted injury, or
3. begins within 6 months after the Effective Date of this certificate as a result of a pre-existing medical condition. A pre-existing medical condition is one for which You received medical advice, diagnosis or treatment by a licensed physician or chiropractor within 6 months prior to the Effective Date shown in the Schedule / Application. When a pre-existing medical condition causes Total Disability, such Total Disability is covered only if it begins after this certificate has been in force for 6 consecutive months.

PART G WHEN INSURANCE STOPS

You can stop this insurance at any time upon written notice to Us, otherwise, this insurance stops on the Scheduled Expiration Date of Insurance, or when Your loan is paid off, renewed, refinanced or otherwise stops, whichever happens first. If Your loan is paid off, renewed, refinanced or otherwise stops prior to the Scheduled Expiration Date of Insurance, You may be entitled to a refund or credit of the unearned premium upon Our receipt of Your written notice to Us. See Part H-Refunds of this certificate. No coverage is provided beyond Your 71st birthday. If the insurance stops prior to the Scheduled Expiration Date of Insurance, You may be entitled to a refund or credit of the unearned premium. See Part H-Refunds of this certificate. If the insurance stops early and a disability claim is in progress, the applicable refund or credit of unearned premium will be made and payments on the disability claim will stop.

PART H REFUNDS

If Your loan terminates early due to prepayment, refinancing, or other reasons, You may be entitled to a refund or a credit to Your account of unearned premium. This refund or credit will be calculated using a formula approved by the Insurance Commissioner. Refunds or credits of less than one dollar will not be paid. The refund or credit amount will not include any interest charges incurred.

To receive a refund or credit of any unearned premium that may be due, You must give Us written notice of the early termination of Your loan. Notice should be mailed to Us at P.O. Box 34350, Omaha, Nebraska 68134-0350. We have the right to require proof of the date of termination of the loan. **If You have a question as to how to obtain a refund, call Us at 1-800-826-6587.**

PART I HOW TO FILE A TOTAL DISABILITY CLAIM

Notice of Claim: You must give Us written notice of a claim within 20 days after it starts or as soon as You can. You may give the notice or You may have someone do it for You. The notice should give Your name and certificate number. Notice should be mailed to Us at Omaha, Nebraska, or to any of Our agents.

Claim Forms: When We receive Your notice, We will send You forms for filing proof of loss. If We do not send them within 15 days, You can meet the proof of loss requirement by giving Us a written statement of what happened. We must receive this statement within the time given for filing proof of loss.

The statement must show the date Total Disability began, the diagnosis, dates of medical treatment and it must be signed by a licensed physician or chiropractor who has treated You for the cause of Total Disability.

Proof of Loss: You must give Us written proof of Your loss within 90 days after the date of the loss or as soon as is reasonably possible. Proof must, however, be furnished no later than 12 months from the time it is otherwise required, except in the absence of legal capacity.

Proof of Continued Disability/Physical Exam and Medical Records: We have the right, at any time, to require proof that You continue to be totally disabled and have not returned to work. We also have the right, at Our expense, to request medical records and at reasonable intervals, to have You examined by a licensed physician chosen by Us. Benefits will end if this proof is not given to Us, or if You fail to have an examination. Benefits will also end if You are no longer totally disabled.

PART J HOW TO FILE A LIFE CLAIM

We must be given an original certified death certificate as proof of a life insurance claim.

PART K PAYMENT OF A TOTAL DISABILITY CLAIM

Subject to written proof of loss, following payment of the initial monthly disability benefit, We will make periodic payment for Total Disability at the end of each 30-day period of continuous Total Disability. For any Period of Total Disability less than one month, We will pay 1/30th of the Maximum Monthly Total Disability Benefit for each day of disability. Any benefits unpaid when Our liability for such Total Disability ends will be paid as soon as We receive proof of loss.

PART L GENERAL PROVISIONS

Application: Your Application for this insurance is made a part of this certificate. No statement made by You relating to Your insurability will be used in contesting the validity of Your insurance with respect to which such statement was made unless it is contained in a written instrument signed by You.

Incontestability/Time Limit on Certain Defenses: After two years from the date You become insured under this certificate, We cannot use misstatements, except fraudulent misstatements, in Your signed Application to void coverage or deny a claim for a loss that happens after the two-year period.

Legal Actions — Total Disability Benefits: You cannot bring a legal action to recover under Your certificate for at least 60 days after You have given Us written proof of loss. You cannot start such an action more than three years after the date proof of loss is required.

Autopsy/Medical Records: We, at Our expense, have the right to request medical records as necessary and to have an autopsy done where it is not prohibited by law while a claim is pending.

Irrevocable Beneficiary: The irrevocable beneficiary under this certificate is the Creditor Beneficiary named in the Schedule/ Application. You may not change the irrevocable beneficiary.

Conformity with State Statutes: The provisions of this certificate must conform with the laws of the state in which the Group Master Policy was issued. If any do not, this clause amends them so that they do conform to the minimum standards of those statutes.

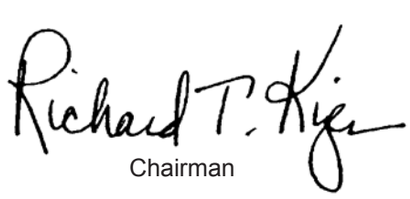
Refinancing, Renewal or Consolidation: When a new certificate is issued due to refinancing, renewal or consolidation of a debt, the Effective Date of the coverage for any provisions in the new certificate will be deemed to be the first date on which the debtor became insured under the previous certificate. This applies only to the amount and term of the outstanding debt of the previous certificate at the time of refinancing, renewal or consolidation.

Maximum Limits: There are maximum limits based on age and amounts of coverage that can be provided under this certificate. There are also maximum aggregate amounts of coverage that can be provided under all certificates You have with Us. Total coverage for loss of life or disability must be within Our maximum limits.

If the total of all coverage exceeds Our maximum limits, one of the following must occur. Prior to an occurrence of a claim, We may adjust the coverage to the maximum limits. We would refund or credit Your account any premium paid for coverage beyond Our maximum limits. After an occurrence of a claim, the amount of coverage shown in the Schedule / Application will not be adjusted.

Schedule / Application: The Schedule / Application and the information it shows is a part of this certificate.

This certificate is signed for Us by the officers named below.



Chairman

President

Central States Health & Life Co. of Omaha

A MUTUAL LEGAL RESERVE COMPANY

Central States Health & Life Co. of Omaha
PRIVACY PRINCIPLES &
NOTIFICATION OF INFORMATION PRACTICES

At Central States Health & Life Co. of Omaha (CSO), we value the trust you have placed in us and maintaining this trust is a high priority for us. We pride ourselves on offering you top quality insurance products and providing you with excellent service. We do this while respecting your right to privacy and using your information only as we agreed.

In order for us to offer our products and services, it is necessary for us to collect a certain amount of information about you. Some of that information might be considered nonpublic personal information. Some examples of this type of information would be:

- **Information on our applications.** This is the information you provided as part of the application process.
- **Information about your transactions with us**. Your file may contain information such as premium payment and claims history that we've developed based upon our transactions and experiences with you.
- **Information we obtain from third parties.** The type of information we gather depends on the type of policy or coverage. This may include motor vehicle reports, claim reports, credit reports and medical reports. We may exchange information with consumer reporting agencies in connection with your application or renewal of insurance coverage with us.

CSO limits the collection, use and access of this information to the minimum required in order to deliver our products and services to you. This may include advising you about other opportunities available through us. Some insurance companies may share information about their customers with nonaffiliated third parties to offer new products or services. The law requires these companies provide you with an opportunity to opt-out or restrict that company from sharing your information. Because CSO does not disclose your nonpublic personal information except where permitted by law, it is not necessary for us to provide you with an opt-out option. Instead, we offer you this pledge:

- We do not disclose any nonpublic personal information about our customers or former customers without their permission to anyone, except as permitted or required by law.
- We have taken what we believe to be reasonable steps to protect the security and privacy of your nonpublic personal information by maintaining physical, electronic and procedural safeguards to protect your nonpublic personal information. We take appropriate disciplinary measures to enforce employee privacy responsibilities.
- Whenever other companies or individuals assist us in providing our products and services that you have requested, we will prohibit them from using or disclosing your information for any purpose other than providing agreed upon services for us. Additionally, we will require them to use appropriate safeguards to protect the information.
- We do not presently share information subject to the Fair Credit Reporting Act among any affiliates. To the extent we make any disclosures in the future of your information which are subject to that Act, we will follow the necessary requirements of the Act including providing you the opportunity to advise us you do not want the information disclosed.
- We strive to keep our records of your information accurate. If you contact us, we will tell you how to access your account information, how we have used the information, and how to notify us about errors. We will promptly correct any inaccurate information.
- We may amend our privacy policy from time to time. As required by law, we will send our current customers our most recent privacy notice at least annually.

At Central States Health & Life Co. of Omaha, we value our relationship with you and appreciate the opportunity to provide you with valuable insurance products. If you should have any questions, please feel free to contact us at:

Central States Health & Life Co. of Omaha
1212 N. 96th Street • Omaha, NE 68114