

MOO/UOO/UW/OIC Contracting Checklist

Please submit the following information to SMS when licensing with UOO FE:

- Signed Final Expense Producer Acknowledgment Form
- Completed and Signed Contract Information Form
- Signed Fair Credit Reporting Act Disclosure
- Signed Life Advance Agreement (optional)
- Copy of current resident/non-resident agent/agency license

Please submit the following information to SMS when licensing with MOO (all products but FE):

- Completed and Signed Contract Information Form
- Signed Fair Credit Reporting Act Disclosure
- Signed Life Advance Agreement (optional)
- Signed Health Advance Agreement (optional)
- Signed Accidental Death Advance Agreement (optional)
- Copy of current resident/non-resident agent/agency license

Please return all contracting to Senior Marketing Specialist via:

Mail:

801 Gray Oak Dr
Columbia, MO 65201

Email:

contracting@smsteam.net

Fax: 800-878-2025

The licensing process cannot begin until all of the above items have been received! If you have any questions, please call us at:

1- 800-689-2800.

Contracting Request Form

Please complete the below and return it with your contracting paperwork:

Agent Name: _____

Carrier Name: _____

1. Have you or your agency (if applicable) ever been contracted previously? (Y/N)

If you answered 'yes' to the question above, please complete the below:

2. What date did you contract?

3. How were you contracted (indv. or corp.)?

4. Do you have any downline agents?

5. When was the last time you or your downline (if applicable) wrote a piece of business?

Mutual of Omaha Product Choices

Please choose from the products below and select ALL that you would like to get appointed to sell!

ANNUITY
DENTAL
FINAL EXPENSE
HEALTH
LIFE
LTC
MED SUPP

Final Expense (Living Promise) Producer Acknowledgement Form

I agree and acknowledge that I will be selling United of Omaha Living Promise Whole Life Insurance through _____.

Marketer Name

Printed Name: _____

Producer Signature: _____



(Signature always required)

Date: _____

SSN: _____

(Required for Individuals)

OR

TIN: _____

(Required for Business Entities)

Production Number: _____

Complete and return this form to your Master General Agency to continue the Living Promise contracting process.

Contract Information and Signature Form



If contracting as a: Producer only - complete sections 1, 3 & Individual FCRA Authorization Form
 Business Entity only - complete sections 2 & 3

Section 1 Business Entity & Principal- complete sections 1, 2, 3 (both signature blocks) & Individual FCRA Authorization Form

Producer Information (Required)

Name: _____ SSN: _____ - _____ - _____ DOB: ____ - ____ - ____
First Name, Middle Initial, Last Name (as it appears on license) MM DD YYYY

Home Address: _____ City _____ State _____ Zip Code _____
Not a P.O. Box

Business Address: _____ City _____ State _____ Zip Code _____
P.O. Box Accepted

Primary Phone Number: ____ - ____ - _____ Business Phone: ____ - ____ - _____ Email Address: _____

Master General Agency (If applicable): _____

Errors & Omission Insurance (As Required): _____ \$ _____
Carrier Name Minimum \$1M Per Claim

Background Information (Required - Must be answered)

Yes	No	Has any regulatory authority, such as an insurance department, FINRA or the SEC ever fined or suspended you, placed you on probation, assessed you any administrative costs, entered into a consent order with you, issued you a restricted license, or otherwise disciplined you? Are you currently under investigation by any regulatory authority, such as an insurance department, FINRA or the SEC?
Yes	No	Other than minor traffic offenses that did not result in harm to a person or property, have you been (1) convicted of any offense, or (2) pled guilty or nolo contendere (no contest) to any offense?

NOTE: Answering "YES" to the above questions does not automatically preclude you from being contracted.

If Yes, please include county _____

Directions: PLEASE PROVIDE A WRITTEN EXPLANATION for any "YES" answer including the disposition and applicable supporting documentation (court documents, insurance department documents etc.). Failure to answer "YES", when appropriate, may result in denial of your request to be contracted.

Contracting Selection (Required) [Please review our Online Privacy Policy at www.mutualofomaha.com/privacy](http://www.mutualofomaha.com/privacy)

<input type="checkbox"/>	I have received, reviewed and agree to be bound by the Terms & Conditions of the General Agent Agreement with Mutual of Omaha and its affiliates (BMO151.013) Please retain a copy of the agreement for your files. A copy will not be returned to you.
<input type="checkbox"/>	I have received, reviewed and agree to be bound by the Terms & Conditions of the Special Agent Agreement with Mutual of Omaha and its affiliates (BMO152.013) Please retain a copy of the agreement for your files. A copy will not be returned to you.

Direct Deposit Information (Complete if you are electing direct deposit - not applicable for Special Agents)

Financial Institution: _____
 Routing Number: _____ Account Number: _____ Account Type Checking Savings

This is not an assignment of commissions. Form 1099 will be issued to the commission owner.

Express Pay Opt In

Eligibility requires Direct Deposit, Electronic Statements and no active Legal Judgments. Express Pay may not be available for all Marketers. Express Pay is calculated every day. (If unselected, default pay cycle is Weekly.)

Designation of Beneficiary (if applicable)

Name: _____ Relationship: _____
First Name, Middle Initial, Last Name or Business Name

Home Address: _____ City _____ State _____ Zip Code _____
Not a P.O. Box

SSN: _____ - _____ - _____ or TIN: _____ - _____ DOB: ____ - ____ - _____ Phone Number: ____ - ____ - _____

W-9 Information

Taxpayer Identification Number (SSN)

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 _____ - ____ - ____

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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Please proceed to Section 3

Contract Information and Signature Form

Section 2

Business Information *(Only complete this section if contracting as an Incorporated Entity, Partnership or LLC)*

Name: _____ TIN: _____
(As Shown On Income Tax Returns)

Doing Business As: _____

Address: _____
P.O. Box Accepted City State Zip Code

Phone: _____ - _____ - _____ Email Address: _____

Principal Officer: _____

Master General Agency *(If applicable)*: _____

Contracting Selection *(Required for Corporation)*

I have received, reviewed and agree to be bound by the Terms & Conditions of the **General Agent Agreement** with Mutual of Omaha and its affiliates **(BMO151.013)**
Please retain a copy of the agreement for your files. A copy will not be returned to you.

Direct Deposit Information *(Complete if you are electing direct deposit)*

Financial Institution: _____

Routing Number: _____ Account Number: _____ Account Type: _____ Checking Savings

This is not an assignment of commissions. Form 1099 will be issued to the commission owner.

Express Pay Opt In

Eligibility requires Direct Deposit, Electronic Statements and no active Legal Judgments. Express Pay may not be available for all marketers. Express Pay is calculated every day. *(If unselected, default pay cycle is Weekly.)*

W-9 Information

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.

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 →
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****Please proceed to Section 3****

Section 3 - Contract Signature, Certification and Direct Deposit Authorization

By signing below:

- (a) you agree to be bound by the terms and conditions of the Agreement(s) selected,
- (b) you certify that the information that you have provided is true and correct and you agree that you will report immediately any event that would change any of the information, in any manner, which you have provided,
- (c) you agree to maintain your state insurance license in good standing, stay current with required continuing education, and obtain and maintain E&O coverage as required, and
- (d) if you have completed the Direct Deposit section(s) you authorize Mutual of Omaha Insurance Company ("Company") and its affiliates to electronically credit the bank account and, if necessary, to electronically debit the account to correct erroneous credits. You understand that this authorization will remain in full force and effect until you notify Company that you wish to revoke this authorization.

Producer Signature

Name: _____
(Signature Required)

Date: _____

Business Signature *(If Signing on the behalf of the Business)*

Name: _____

Title: _____
(Required)

Date: _____

****Please proceed to the FCRA Authorization Form****

State Appointment Requests- To add the appointment the producer must have an active state license

Please mark the state appointments to be added for this producer: Please include license copies, grid or NIPR report.

If no copies, grid or NIPR report are received only the resident state will be added

Producer Name _____ SSN/Producer Number _____

All States Licensed

Alabama	Kentucky	North Carolina
Alaska	Louisiana	North Dakota
Arizona	Maine	Ohio
Arkansas	Maryland	*Oklahoma
California	*Massachusetts	Oregon
Colorado	Michigan	*Pennsylvania
Connecticut	Minnesota	Rhode Island
Delaware	Mississippi	South Carolina
Florida	Missouri	South Dakota
*Georgia	*Montana	Tennessee
Hawaii	Nebraska	Texas
Idaho	Nevada	Utah
Illinois	New Hampshire	Vermont
Indiana	New Jersey	*Virginia
Iowa	*New Mexico	Washington
Kansas	New York	West Virginia
		Wisconsin
		Wyoming

***IMPORTANT NOTICE REGARDING COMPENSATION:**

Entity Type	State
<ul style="list-style-type: none"> Licenses and Appointment required for both Individuals and Corporations. License must be effective prior to the policy application sign date 	Montana Virginia
<ul style="list-style-type: none"> Licenses and Appointment required for both Individuals and Corporations 	Georgia Massachusetts New Mexico Pennsylvania

***If individuals and corporations do not follow the above guidelines for the states referenced, compensation will be held on anyone in the hierarchy who does not hold the license and appointment.**

***States listed in either red or half red & blue are pre-appointment states and require the producer to be appointed prior to soliciting business**

FAIR CREDIT REPORTING ACT DISCLOSURE

Disclosure Regarding Consumer Reports

Mutual of Omaha Insurance Company and its affiliates with which you intend to contract (together, "Mutual of Omaha") may obtain and use consumer reports about you in order to evaluate your eligibility to contract with Mutual of Omaha as an insurance producer or to remain contracted as an insurance producer for Mutual of Omaha.

Your Authorization

By signing below, I authorize Mutual of Omaha to obtain and use consumer reports about me in order to evaluate my eligibility to contract with Mutual of Omaha as an insurance producer. If I do contract with Mutual of Omaha as an insurance producer, by signing below, I also authorize Mutual of Omaha to obtain and use consumer reports about me while my contract is in effect in order to evaluate my continued eligibility to remain an insurance producer for Mutual of Omaha.

 SIGN HERE

Candidate Signature

Date

Print Name

Additional Information About Consumer Reports

Consumer reports may include, among other things, information about your credit history, criminal record and history, and insurance department regulatory actions.

We will obtain a copy of your consumer report from:

Name/Address/Phone

For 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.

HEALTH ADVANCE

SELECTION OF ADVANCE COMMISSION OPTION. Please select **ONE** of the advance commission options from the choices below and acknowledge choice by placing your initials beside your selection. All choices are for advance of commission upon the issuance of an eligible product.

6 Month Advance Options		
Select ONE	Maximum Amount per Policy	For Internal Use
	\$1000	QZ3, QZ4, QZ5
	\$2000	QZ6, QZ8, QZ8
	\$3000	RA4, RA5, RA6

OR

9 Month Advance Options		
Select ONE	Maximum Amount per Policy	For Internal Use
	\$1000	QR2, QR3, QR4
	\$2000	QR8, QR9, QS1
	\$3000	QS5, QS6, QS7
	\$4000	RA7, RA8, RA9


OR

12 Month Advance Options		
Select ONE	Maximum Amount per Policy	For Internal Use
	\$1000	QR5, QR6, QR7
	\$2000	QS2, QS3, QS4
	\$3000	QS8, QT1, QS9
	\$4000	QT2, QT3, QT4
	\$5000	RB1, RB2, RB3

**Select
Only
One
Option**

I wish to be paid AS EARNED

**MUTUAL OF OMAHA INSURANCE COMPANY
UNITED OF OMAHA LIFE INSURANCE COMPANY
UNITED WORLD LIFE INSURANCE COMPANY
OMAHA INSURANCE COMPANY
OMAHA SUPPLEMENTAL 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.

LIFE ADVANCE

SELECTION OF ADVANCE COMMISSION OPTION. Please select **ONE** of the advance commission options from the choices below and acknowledge choice by placing your initials beside your selection. All choices are for advance of commission upon the issuance of an eligible product.

6 Month Advance Options		
Select One	Maximum Amount per Policy	For Internal Use
	\$1000	QV7
	\$2000	QV9
	\$3000	RC1

OR

9 Month Advance Options		
Select One	Maximum Amount per Policy	For Internal Use
	\$1000	QV8
	\$2000	QW1
	\$3000	QW2
	\$4000	RC2

SELECT
ONE
OPTION
ONLY

I wish to be paid AS EARNED

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

Please Note: The Debt Verification Authorization form must also be signed and must accompany this signature page before advancing will be considered for approval.

GENERAL AGENT/REPRESENTATIVE	
BY: _____ (Signature always required)	SOCIAL SECURITY or TAX ID NUMBER: _____
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.

ACCIDENTAL DEATH ADVANCING

SELECTION OF ADVANCE COMMISSION OPTION. Please select **ONE** of the advance commission options from the choices below. All choices are for advance of commission upon the issuance of an eligible Product.

3 MONTH OPTION		
Select One	Max. Amount per policy	For Internal Use Only
	\$100	A62
	\$200	A63

6 MONTH OPTION		
Select One	Max. Amount per policy	For Internal Use Only
	\$100	A64
	\$200	A65
	\$300	A66

9 MONTH OPTION		
Select One	Max. Amount per policy	For Internal Use Only
	\$100	A67
	\$200	A68
	\$300	A69
	\$500	A70

Select
One
Option
Only

I wish to be paid AS EARNED

**MUTUAL OF OMAHA INSURANCE COMPANY
ACCIDENTAL DEATH
ISSUE ADVANCE COMMISSION AMENDMENT**

GENERAL AGENT/REPRESENTATIVE	
BY: _____ (Signature always required)	SOCIAL SECURITY or TAX ID NUMBER: _____
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.