

Thank you for your interest in applying for the Mutual of Omaha Medicare Supplement plan!

This application needs to be reviewed and signed by an Agent before it can be submitted to Mutual of Omaha. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Download Policy Outline (.pdf)

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Producer Name

Agent Writing Number
or Social Security Number

Commission Share

Commission Code- Required only if
you are not appointed or licensed or
are changing brokerage firms



Dann Loewenthal

0	3	0	1	6	7	2			
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1	0	0	%		
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none

--	--	--	--	--	--	--	--	--	--

			%		
--	--	--	---	--	--

Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at <http://www.mutualofomaha.com/>.

Application Submission Checklist – Mutual of Omaha Medicare Supplement Coverage

Provide Applicant with the Guide to Health Insurance for People with Medicare

Provide Applicant with the Outline of Coverage

- Calculate the premium based on age at application date

Application (complete in full)

Sections A & B: Plan and Applicant Information

- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

Section C: Medicare Information

- Include applicant’s Medicare claim number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate “eligibility” and “enrollment” dates.

Section D: Previous or Existing Coverage Information

- Please complete ALL questions in full

For Sections E and F – Refer to the Open Enrollment/Guaranteed Issue worksheet (M27788) to help identify eligibility.

Section E: Please answer all of the following questions

- If either Applicant A or B answered “YES” to both questions 5 and 6 in Section E, they can skip to Section H

Sections F & G: Health/Medication Information

- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section H: Agreement and Authorization

- Make sure applicant(s) sign and date the application

Section J: To be Completed by Producer

- Make sure producer(s) sign and date the application

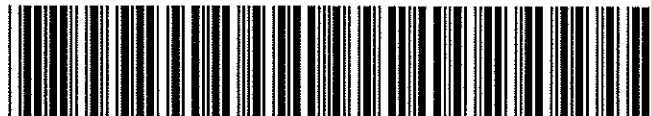
Complete the Method of Payment form (M27784) and return with the completed application

- Use premium determined by the Outline of Coverage
- The full modal premium is collected at the time of application

Complete Replacement Notice (M18362-45_0508) and leave a copy with the applicant (if applicable)

Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices (M27789)

Note: An interviewer may call to verify/confirm the information provided on the application.
This form is required if splitting commissions.



MAP538_WA_0611

Open Enrollment and Guaranteed Issue Worksheet

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period: (Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

ELIGIBILITY FOR OPEN ENROLLMENT

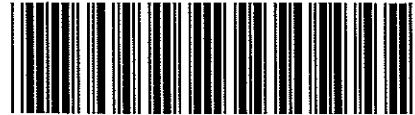
Applicant is:

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.



Applicant:

- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Acceptable Evidence of Eligibility:

- a. Copy of the applicant's MA plan's termination notice
- b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- d. Certification of group coverage
- e. Copy of the termination letter from employer or group carrier
- f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)

B. Applicant Information (continued)

Applicant A

Applicant B

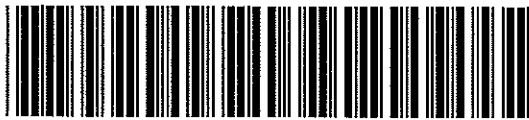
Go paperless! To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from Mutual of Omaha.

Receive statement online? Y N

Receive statement online? Y N

C. Medicare Information

Please reference your Medicare card to complete this section.



MEDICARE HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY JANE DOE	
MEDICARE CLAIM NUMBER 000-00-0000-A	SEX FEMALE
IS ENTITLED TO HOSPITAL (PART A) → MEDICAL (PART B) →	EFFECTIVE DATE 07-01-2010 07-01-2010

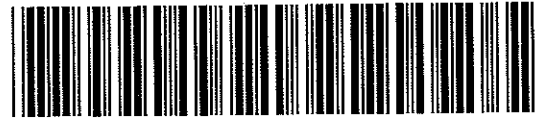
Applicant A

Applicant B

Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medicare Part B Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Medicare Part B Effective Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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D. Previous or Existing Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:

1. Are you covered for medical assistance through the state Medicaid program?.....
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)

Applicant A

Y N

Applicant B

Y N

If "YES," answer the following about this existing coverage:

(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....

Y N

Y N

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....

Y N

Y N

Please answer questions regarding another Medicare supplement or Select plan:

2. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....

Y N

Y N

If "YES," answer the following about this existing coverage:

(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....

Y N

Y N

(b) Indicate planned termination or disenrollment date..... Applicant A

____/____/____

Applicant B

____/____/____

(c) With what company, and what plan do you have?

Applicant A
Name of Company
Plan
Effective Date

Applicant B
Name of Company
Plan
Effective Date

Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

3. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....

Y N

Y N

If "YES," answer the following about this previous or existing coverage:

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank..... Applicant A

START ____/____/____

END ____/____/____

Applicant B

START ____/____/____

END ____/____/____

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....

Y N

Y N

(c) Planned date of termination/disenrollment?..... Applicant A

____/____/____

Applicant B

____/____/____

(d) Was this your first time in this type of Medicare plan?.....

Y N

Y N

(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....

Y N

Y N

(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..

Y N

Y N

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(g) Please indicate reason for termination/disenrollment:

- Your Medicare Advantage plan is leaving the Medicare program.....
- Your Medicare Advantage organization stopped offering Medicare Advantage plans.....
- Your Medicare Advantage organization stopped offering coverage in the area in which you live.....
- You moved out of the geographic service area of your Medicare Advantage plan.....
- You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....
- Other: _____

Applicant A

Applicant B

Check box(s) below if applicable

Applicant A

Applicant B

Please answer questions regarding other health insurance:

4. Have you had coverage under any other health insurance within the past 63 days?.....
(For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)

Applicant A

Applicant B

Y N

Y N

If "YES," answer the following about this previous or existing coverage:

(a) What are your dates of coverage under the other policy/certificate?

If you are still covered under this plan, leave "END" blank..... Applicant A START

____/____/____

END

____/____/____

Applicant B START

____/____/____

END

____/____/____

(b) Planned date of termination/disenrollment?..... Applicant A

____/____/____

Applicant B

____/____/____

(c) With what company and what kind of policy/certificate? (List below.)

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

E. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

5. Did you turn age 65 in the last six months?.....

Applicant A

Applicant B

Y N

Y N

6. Did you enroll in Medicare Part B in the last six months?.....

Y N

Y N

If "YES," indicate your effective date..... Applicant A

____/____/____

Applicant B

____/____/____



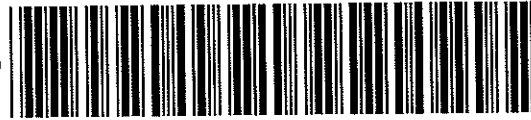
IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO BOTH QUESTIONS 5 AND 6 IN SECTION E, SKIP SECTIONS F & G AND GO TO SECTION H.



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**If you are applying during an open enrollment or guaranteed issue period:
SKIP SECTIONS F & G and GO TO SECTION H.**

F. Health Information

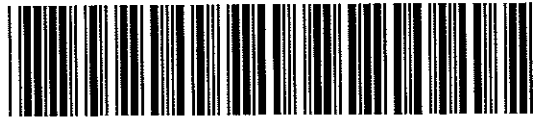


For all plans, answer questions 7-15.

(If "YES" is answered to any of the following questions 7-15, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
7. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
10. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's Disease, dementia or any other cognitive disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic Lupus or Myasthenia Gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
H. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
I. Osteoporosis with fractures?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alcoholism or drug abuse?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Internal cancer, lymphoma or melanoma?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Have you been hospital confined three or more times in the past two years for a same or similar condition?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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G. Medication Information

If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

Applicant A

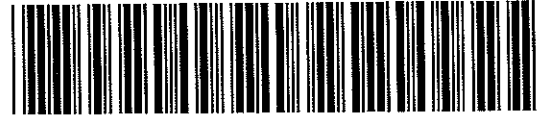
Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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H. Agreement and Authorization



IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO MUTUAL OF OMAHA INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Mutual of Omaha. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Mutual of Omaha Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha has taken action in reliance on the authorization or the law allows Mutual of Omaha to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Mutual of Omaha.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

Fraud Warning: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Dated at _____, on _____/_____/_____, _____
 City State Month Day Year Applicant A's Signature

Dated at _____, on _____/_____/_____, _____
 City State Month Day Year Applicant B's Signature (if applying)

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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN

Part I. Select Premium Payment Option

Initial Premium (Select option #1 or #2) <input type="checkbox"/> Initial premium amount (based on age at application date) 1. Paper Check (submit signed check with application)..... 2. Automated Bank Account Withdrawal..... Ongoing Premium Payments (Select option #1 or #2) 1. I want my payments automatically withdrawn from my bank account every month on (Circle date)..... 2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....	Applicant A \$ _____ <input type="checkbox"/> <input type="checkbox"/> 1 st or 15 th every _____ months Insert 3, 6, or 12	Applicant B \$ _____ <input type="checkbox"/> <input type="checkbox"/> 1 st or 15 th every _____ months Insert 3, 6, or 12
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Part II. Payor Information

Complete the following if premium is NOT paid by applicant (includes spouse or joint-married account): 1. Account Owner Name , if different than applicant's..... 2. Account Owner Relationship to applicant: Employer Living Trust Power of Attorney or legal guardian (documentation required) Business owned by applicant or applicant's spouse	Applicant A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Applicant B <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
 This section is intended as authorization to debit your bank account.
 Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here	Applicant A Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings Name of Financial Institution _____ Routing Number (9 digits on lower left side of check) _____ Account Number (Do NOT use Debit/Credit Card numbers) _____ Name as Shown on Account _____	Applicant B <input type="checkbox"/> Same account as Applicant A Account Type (check one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings Name of Financial Institution _____ Routing Number (9 digits on lower left side of check) _____ Account Number (Do NOT use Debit/Credit Card numbers) _____ Name as Shown on Account _____
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- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

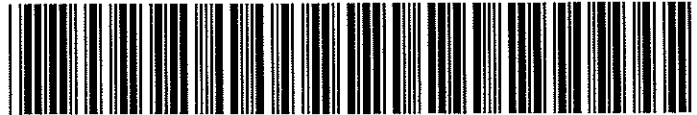


Example:

Account Holder Name	John Doe	Check #1234
Street Address	_____	Date: _____
Town, City ZIP Code	_____	
Pay to:	_____	
Routing/Transfer Number	_____	Account Number
Financial Institution Name & Address	_____	Dollars
Signed By:	_____	
1:123456789: 12345678 1234		

IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY. The first withdrawal date may be different from the monthly date selected for renewal premiums.
 I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account to Mutual of Omaha any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

<input type="checkbox"/> _____ Authorized Signature as Shown on Account _____ Date	<input type="checkbox"/> _____ Authorized Signature as Shown on Account _____ Date
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NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Insurance Producer or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

Applicant A	Applicant B
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____
_____	_____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.



Signature of Issuer, Insurance Producer or Other Representative* **Date**
 Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175

M18362-45_0508

Applicant A	Applicant B
Signature 	Signature
Date	Date

*Signature not required for direct response sales.

IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

Replacement Notice

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

Premium Receipt / Notice of Information Practices



NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Insurance Producer or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

Applicant A	Applicant B
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____
_____	_____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.



Signature of Issuer, Insurance Producer or Other Representative* **Date**
 Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175

M18362-45_0508

Applicant A	Applicant B
Signature 	Signature
Date	Date

*Signature not required for direct response sales.

MUTUAL of OMAHA INSURANCE COMPANY

Premium Receipt

All premiums must be made payable to Mutual of Omaha Insurance Company.

Do not make check payable to the agent or leave the payee blank.

Applicant A

Applicant B

Received from _____

Received from _____

this ____ day of _____, _____

this ____ day of _____, _____

an application for Form _____ Policy

an application for Form _____ Policy

and/or Riders _____ and _____

and/or Riders _____ and _____

Check for _____ Dollars.

Check for _____ Dollars.

 Agent _____

 Agent _____

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, Mutual of Omaha Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.



Notice of Information Practices

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

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

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

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

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

Provide the completed premium receipt, if applicable, and notice to the applicant.

M27789

INSTRUCTIONS FOR COMPLETION OF AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (ACH/BSP) FORM

Account Holder Name	Check Number																
<div style="border: 2px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">John Doe</td> <td style="width: 40%; text-align: right;">Check #1234</td> </tr> <tr> <td>Street Address</td> <td>Date: _____</td> </tr> <tr> <td>Town, City Zip code</td> <td></td> </tr> <tr> <td>Pay to: _____</td> <td></td> </tr> <tr> <td>_____ Dollars</td> <td></td> </tr> <tr> <td>Bank Name & Address</td> <td></td> </tr> <tr> <td>Memo _____</td> <td>Signed By: _____</td> </tr> <tr> <td colspan="2" style="text-align: center;"> ⑆123456789⑆ 12345678 ⑆ 1234 ⑆ </td> </tr> </table> </div>		John Doe	Check #1234	Street Address	Date: _____	Town, City Zip code		Pay to: _____		_____ Dollars		Bank Name & Address		Memo _____	Signed By: _____	⑆123456789⑆ 12345678 ⑆ 1234 ⑆	
John Doe	Check #1234																
Street Address	Date: _____																
Town, City Zip code																	
Pay to: _____																	
_____ Dollars																	
Bank Name & Address																	
Memo _____	Signed By: _____																
⑆123456789⑆ 12345678 ⑆ 1234 ⑆																	
Bank Routing/ Transfer Number	Bank Account Number	Check Number (if shown at bottom, may be before or after the account #)	Do NOT include the check number as part of either the Routing or Account Number.														

The applicant may select one of three payment options indicated on the back side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer (EFT).

Automatic Clearing House (ACH) is used for initial payment and **Bank Service Plan (BSP)** is used for renewal payments. When choosing to pay both the initial and monthly renewals by EFT, the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP

When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A signed check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)

When choosing to pay the initial premium by ACH and renewal premiums by direct billing (annually, semiannually, or quarterly), the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for the initial premium payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premium by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments can not be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the ACH/BSP form accurately and in its entirety, making sure that all required information is correct and complete on your ACH/BSP form prior to submission. In addition, please make sure that the premium amount is filled in on the ACH/BSP form, so we can initiate a timely and accurate withdrawal from your client's bank account.

An example of how to find correct Routing and Account Numbers on your clients' checks is included at the top of this form. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.

Mutual of Omaha Insurance Company or United World Life Insurance Company

Please refer to instructions
on the Front of this form.

Authorization for Electronic Funds Transfer (ACH/BSP)

This form is intended as authorization to debit your account. Please complete initial and renewal premium payment information below.

Medicare Supplement Premium Payment Options:	YES	NO
A. Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer..... (ACH is used for initial payment and BSP is used for renewal payments.)	<input type="checkbox"/>	<input type="checkbox"/>
B. Pay initial premium by signed paper check and pay monthly renewals by BSP	<input type="checkbox"/>	<input type="checkbox"/>
C. Pay initial premium by ACH and pay renewals by direct bill (<u>monthly direct billing is not offered</u>)	<input type="checkbox"/>	<input type="checkbox"/>
• If choosing Options A or C, list amount of initial premium withdrawal, if applicable	\$ _____	
• If choosing Options A or B, select a withdrawal date for monthly BSP renewal payments (circle one)	1st	or 15th
• Is a business account being used to pay premiums?.....	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, is the applicant:		
(a) Unemployed.....	<input type="checkbox"/>	<input type="checkbox"/>
(b) Employed, but not working for the business that is paying the premium	<input type="checkbox"/>	<input type="checkbox"/>
(c) The business owner or spouse of the business owner	<input type="checkbox"/>	<input type="checkbox"/>

If (a), (b), or (c) are "Yes," premiums CAN be paid with a business account.

Account Type (check one): Checking Savings

Complete information below. To avoid potential delays in processing, submit a copy of a voided check.

Name of Financial Institution

Routing Number (first 9 digits on lower left side of check)

Account Number (Do NOT use Debit or Credit Card account numbers)

Name as Shown on Account

IMPORTANT: Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected above.

I authorize Mutual of Omaha and/or United World Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize Mutual of Omaha and/or United World Life Insurance Company to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Mutual of Omaha and/or United World Life Insurance Company. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Authorized Signature as Shown on Account

Date