

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

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

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

**Preferred Method of Communication (Select one)**
☐ Phone   ☐ Fax   ☐ Email   Contact info: \_\_\_\_\_

**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 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

**Section E: Please answer all of the following questions****Section F: Agreement and Authorization**

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

**Section H: To be Completed by Producer**

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

☐ Complete the Method of Payment form 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 and leave a copy with the applicant (if applicable)

☐ Provide Applicant with Premium Receipt signed by agent (if applicable)

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

# 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

*If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.*

*If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, 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

*If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.*

*If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, 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 obtain their Medicare supplement policy back if that carrier still sells it or, if not available:*

- If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.*
- If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.*

Applicant was enrolled in a Medicaid plan or state-specific variation of a Medicaid plan, and:

- the applicant's state has Guaranteed Issue or Open Enrollment Rights for the loss of Medicaid or state-specific variation of a Medicaid plan

*Reference the Underwriting Guidelines for states that have Guarantee Issue or Open Enrollment Rights for loss of Medicaid or state-specific variation of a Medicaid plan.*

Acceptable Evidence of Eligibility (Can vary by situation, refer to Underwriting Guide):

- Copy of the applicant's MA plan's termination notice
- Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- Certification of group coverage
- Copy of the termination letter from employer or group carrier
- Image of insurance ID card (**ONLY** allowed if your MA plan is being terminated)
- Copy of the termination letter that the applicant received regarding their state Medicaid plan or state-specific variation of a Medicaid plan

Agent Writing #

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FAV Key \_\_\_\_\_ Auth # \_\_\_\_\_

Group # (if applicable) \_\_\_\_\_ Keyline \_\_\_\_\_

**Mutual of Omaha**Underwritten by  
Mutual of Omaha Insurance Company3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175**Application for Medicare Supplement Coverage**

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

**A. Plan Information (to be completed by Producer)****Applicant A**

Plan (select one):

☐

Plan A

☐

Plan B

☐

Plan D

☐

Plan G

☐

Plan G - High Deductible

☐

Plan N

**OR**If your Medicare Part A eligibility date is before 01/01/2020, these **additional** plans are available options:☐

Plan C

☐

Plan F

☐

Plan F - High Deductible

Requested Effective Date

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

Deliver Policy to

Applicant A ☐Producer ☐**Applicant B**

Plan (select one):

☐

Plan A

☐

Plan B

☐

Plan D

☐

Plan G

☐

Plan G - High Deductible

☐

Plan N

**OR**If your Medicare Part A eligibility date is before 01/01/2020, these **additional** plans are available options:☐

Plan C

☐

Plan F

☐

Plan F - High Deductible

Requested Effective Date

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

Deliver Policy to

Applicant B ☐Producer ☐**B. Applicant Information****Applicant A**

Name (First/Middle/Last)
Residence Address
City
State
ZIP
Mailing Address (if different from residence address)
City
State
ZIP
Home Phone
(area code)
E-mail Address
Current Age
Date of Birth
mo day yr
<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #
Height
Ft In
Weight
Lbs

**Applicant B**

Name (First/Middle/Last)
Residence Address (if different from Applicant A's)
City
State
ZIP
Mailing Address (if different from residence address)
City
State
ZIP
Home Phone
(area code)
E-mail Address
Current Age
Date of Birth
mo day yr
<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #
Height
Ft In
Weight
Lbs

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## B. Applicant Information (continued)

### Applicant A

If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease?..... ☐ Y ☐ N

### Applicant B

If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease?..... ☐ Y ☐ N

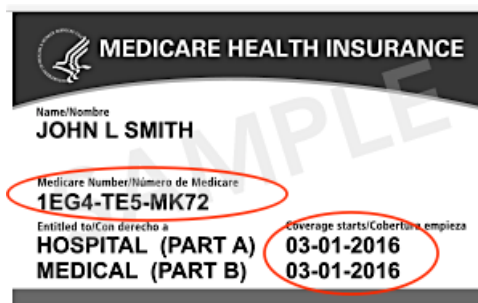
**Go paperless!** To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each 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.



### Applicant A

Medicare Number

Medicare Part A Effective Date / /

If you are not covered under Medicare Part A, what is your eligibility date / /

Medicare Part B Effective Date / /

If you are not covered under Medicare Part B, indicate the date you plan to enroll / /

### Applicant B

Medicare Number

Medicare Part A Effective Date / /

If you are not covered under Medicare Part A, what is your eligibility date / /

Medicare Part B Effective Date / /

If you are not covered under Medicare Part B, indicate the date you plan to enroll / /





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:	<b>Applicant A</b>	<b>Applicant B</b>
1. Are you covered for medical assistance through the state Medicaid program?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(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.)		
<b>If "YES," answer the following about this existing coverage:</b>		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(c) Do you receive any benefits from the Vermont Health Access Plan (VHAP) program? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this existing coverage:</b>		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
(c) With what company, and what plan do you have?		

<b>Applicant A</b>	<b>Applicant B</b>
Name of Company	Name of Company
Plan	Plan

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).....	<b>Applicant A</b>	<b>Applicant B</b>
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this previous or existing coverage:</b>		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....	Applicant A START <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
	END <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
	END <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(c) Planned date of termination/disenrollment?.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
(d) Was this your first time in this type of Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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		Check box(s) below if applicable	
		Applicant A	Applicant B
(g) Please indicate reason for termination/disenrollment:			
■ Your Medicare Advantage plan is leaving the Medicare program.....		<input type="checkbox"/>	<input type="checkbox"/>
■ Your Medicare Advantage organization stopped offering Medicare Advantage plans.....		<input type="checkbox"/>	<input type="checkbox"/>
■ Your Medicare Advantage organization stopped offering coverage in the area in which you live.....		<input type="checkbox"/>	<input type="checkbox"/>
■ You moved out of the geographic service area of your Medicare Advantage plan.....		<input type="checkbox"/>	<input type="checkbox"/>
■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....		<input type="checkbox"/>	<input type="checkbox"/>
■ Other: _____			
Applicant A _____			
Applicant B _____			

**Please answer questions regarding other health insurance:**

	Applicant A	Applicant B
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.)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this previous or existing coverage:</b>		
(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 <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B START <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
	END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	END <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(b) Planned date of termination/disenrollment?.....	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>
(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:	Applicant A	Applicant B
5. Are you applying during a guaranteed issue period?..... (If the answer above is "YES," attach proof of eligibility.)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Did you turn age 65 in the last six months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Did you enroll in Medicare Part B in the last six months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," indicate your effective date.....</b>	Applicant A <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>	Applicant B <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/> / <input type="text"/>



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## F. 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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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) and the Vermont Health Access Plan (VHAP) pharmacy program.

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** (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

 Dated at \_\_\_\_\_, on 

Month		Day		Year			

 \_\_\_\_\_  
City State Month Day Year Applicant A's Signature

 Dated at \_\_\_\_\_, on 

Month		Day		Year			

 \_\_\_\_\_  
City State Month Day Year Applicant B's Signature (if applying)





G. Producer Comments (please attach a separate sheet if needed)




H. To be Completed by Producer

8. Producers shall list any other health insurance policies/certificates they have sold to the applicant.  
(a) List policies/certificates sold to the applicant which are still in force.


Applicant A
Applicant B


(b) List policies/certificates sold to the applicant in the past five (5) years which are no longer in force.

Applicant A
Applicant B

I/We certify as follows:

I/We have provided a copy of the replacement notice if the applicant is replacing coverage..... ☐ Y ☐ N  
I/We have accurately recorded in the application the information supplied by the applicant..... ☐ Y ☐ N  
I/We certify that we have interviewed the proposed applicant..... ☐ Y ☐ N  
If you answered "NO" to any of the above statements, please explain why. \_\_\_\_\_  
\_\_\_\_\_

  
\_\_\_\_\_  
Signature of Licensed Producer  
  
\_\_\_\_\_  
Printed Name  
  
\_\_\_\_\_  
Agent Writing Number

  
\_\_\_\_\_  
Signature of Licensed Producer  
  
\_\_\_\_\_  
Printed Name  
  
\_\_\_\_\_  
Agent Writing Number


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# METHOD OF PAYMENT FORM

REQUIRED FORM - PLEASE RETURN PAGES 1 & 2

## Part I. Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)	Applicant A	Applicant B
<p> <b>Initial premium amount</b> (based on age at application 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"/> <input type="text"/></p> <p>1. Paper Check (submit signed check with application)..... <input type="checkbox"/></p> <p>(California collect only one month's premium at time of application)</p> <p>2. Automatic Bank Account Withdrawal..... <input type="checkbox"/></p>	<p>1<sup>st</sup> through the 28<sup>th</sup> or the last day of every month</p> <p>Week (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, last)</p> <p>Weekday (Mon, Tue, Wed, Thu, Fri)</p>	<p>1<sup>st</sup> through the 28<sup>th</sup> or the last day of every month</p> <p>Week (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, last)</p> <p>Weekday (Mon, Tue, Wed, Thu, Fri)</p>
<p><b>Ongoing Premium Payments (Select option #1a, #1b, or #2)</b></p> <p>1. I want my payments automatically withdrawn from my bank</p> <p>a. Choose the day payments will be deducted every month from your bank account.....</p> <p style="text-align: center;">OR</p> <p>b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)</p>	<p>every _____ months Insert 3, 6, or 12</p>	<p>every _____ months Insert 3, 6, or 12</p>
<p>2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing).....</p>		

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed in force, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured(s) will not receive premium billing notices while on this premium payment option. We CANNOT establish electronic payments from foreign banks.

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.

## Part II. Payor Information

	Applicant A	Applicant B
1. <b>Account Owner Name</b> , if different than applicant's.....	_____	_____
2. If premium is <b>NOT</b> paid by Proposed Insured/Insured ( <b>includes spouse or joint-married account</b> ), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.		
Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)	<input type="checkbox"/>	<input type="checkbox"/>
Living Trust	<input type="checkbox"/>	<input type="checkbox"/>
Power of Attorney or legal guardian (documentation required)	<input type="checkbox"/>	<input type="checkbox"/>
Business owned by applicant or applicant's spouse	<input type="checkbox"/>	<input type="checkbox"/>



Part III. Account Information

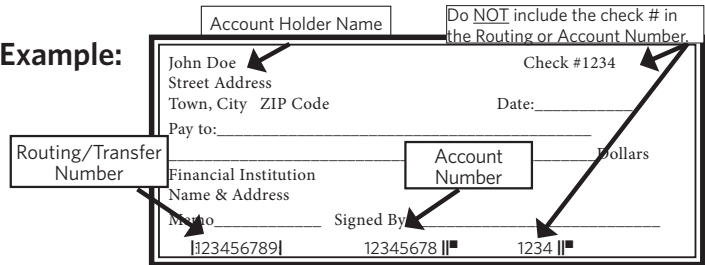
Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:  
This section is intended as authorization to debit your bank account.  
Complete bank account information below OR attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

**Applicant A**  
Account Type (check one): ☐ Checking ☐ 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** ☐ Same account as Applicant A  
Account Type (check one): ☐ Checking ☐ 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  
\_\_\_\_\_

- 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.



I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. This authorization shall apply to any future payments unless specifically revoked by me. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

**Applicant A**  
  
Authorized Signature as Shown on Account  
\_\_\_\_\_  
Date  
\_\_\_\_\_

**Applicant B**  
  
Authorized Signature as Shown on Account  
\_\_\_\_\_  
Date  
\_\_\_\_\_





## 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, Agent, Broker 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

- ☐ Additional benefits  
☐ No change in benefits, but lower premiums  
☐ Fewer benefits and lower premiums  
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D  
☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)  
☐ Other (please specify)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### Applicant B

- ☐ Additional benefits  
☐ No change in benefits, but lower premiums  
☐ Fewer benefits and lower premiums  
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D  
☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)  
☐ Other (please specify)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If, you still wish to terminate your present policy or certificate 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 or certificate until you have received your new policy and are sure that you want to keep it.



Signature of Agent, Broker or Other Representative\*

Date

Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175

#### Applicant A

Signature 	Signature 
Date	Date

#### Applicant B

\*Signature not required for direct response sales.

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

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

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#### Applicant A

- ☐ Additional benefits  
☐ No change in benefits, but lower premiums  
☐ Fewer benefits and lower premiums  
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D  
☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)  
☐ Other (please specify)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### Applicant B

- ☐ Additional benefits  
☐ No change in benefits, but lower premiums  
☐ Fewer benefits and lower premiums  
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D  
☐ Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)  
☐ Other (please specify)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If, you still wish to terminate your present policy or certificate 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.

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Signature of Agent, Broker or Other Representative\*

Date

Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175

#### Applicant A

#### Applicant B

Signature 	Signature 
Date	Date

\*Signature not required for direct response sales.

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Underwritten by  
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza  
Omaha, Nebraska 68175

## 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

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and  
Check for \_\_\_\_\_ Dollars.

 Agent \_\_\_\_\_

### Applicant B

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and  
Check for \_\_\_\_\_ Dollars.

 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.



Provide the completed premium receipt, if applicable.

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