

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



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				%
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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 - United 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

☐ Complete the Calculate Your Premium form to determine rate

☐ 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: Household Premium Discount Information

- Indicate if eligible for a Household Premium Discount

Section E: Previous or Existing Coverage Information

- Please complete ALL questions in full

For Sections F and G - Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility.

Section F: Please answer all of the following questions

- If either Applicant A or B answered "YES" to question BOTH questions 7A AND 7B OR question 8 in Section F, they can skip to Section I

Sections G & H: Health/Medication Information

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

Section I: Agreement and Authorization

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

Section K: 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 **Calculate Your Premium form**
- 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), and with Notice of Information Practices

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



Mutual of Omaha is excited to introduce our new comprehensive wellness program called Mutually Well. Please visit www.mutuallywell.com for more information and to enroll.

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):

- 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)
- g. Copy of the termination letter that the applicant received regarding their state Medicaid plan or state-specific variation of a Medicaid plan

Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan **Applicant A** _____

Applicant B _____

Before you begin: Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	Age Write in your age at the time of signing the application. ZIP Code Indicate your ZIP Code used to determine your rate.	65 51502		
#2	Premium Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	\$128.52		
#3	Household Premium Discount Please refer to the application for state specific household discount premium rules. If the rules apply , multiply the amount from Step #2 by .88. If the rules do not apply , enter the amount from Step #2.	$\$128.52 \times .88 =$ \$113.10 In this example, the person qualifies for the household premium discount.		
#4	Rate Adjustment If you're in your open enrollment or guaranteed issue period, skip to Step #5. Locate your height, then weight on the next page. <ul style="list-style-type: none"> If your weight is in the Standard column, enter the amount from Step #3 If your weight is in the Class I or II column, multiply the amount from Step #3 by: 1.10 if in Class I column 1.20 if in Class II column 	$\$113.10 \times 1.20 =$ \$135.70 Person's weight is in the Class II column.		
#5	Payment Options Your monthly payment is your last premium entered (Step #3 or #4). To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	\$135.70 monthly payment \$407.10 quarterly payment \$814.20 semiannual payment \$1,628.40 annual payment		

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Height and Weight Chart

Eligibility

Find your height in the left-hand column and look across the row to find your weight. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time.

Rate Adjustment

The column heading above your weight will indicate your appropriate rate adjustment, if any (risk class).

	Decline	Class I (10%)	Standard	Class I (10%)	Class II (20%)	Decline
Height	Weight	Weight	Weight	Weight	Weight	Weight
4' 2"	< 54	54 - 60	61 - 110	111 - 128	129 - 145	146 +
4' 3"	< 56	56 - 62	63 - 114	115 - 133	134 - 151	152 +
4' 4"	< 58	58 - 65	66 - 119	120 - 138	139 - 157	158 +
4' 5"	< 60	60 - 67	68 - 123	124 - 143	144 - 163	164 +
4' 6"	< 63	63 - 70	71 - 128	129 - 149	150 - 170	171 +
4' 7"	< 65	65 - 73	74 - 133	134 - 154	155 - 176	177 +
4' 8"	< 67	67 - 75	76 - 138	139 - 160	161 - 182	183 +
4' 9"	< 70	70 - 78	79 - 143	144 - 166	167 - 189	190 +
4' 10"	< 72	72 - 81	82 - 148	149 - 172	173 - 196	197 +
4' 11"	< 75	75 - 84	85 - 153	154 - 178	179 - 202	203 +
5' 0"	< 77	77 - 87	88 - 158	159 - 184	185 - 209	210 +
5' 1"	< 80	80 - 89	90 - 164	165 - 190	191 - 216	217 +
5' 2"	< 83	83 - 92	93 - 169	170 - 196	197 - 224	225 +
5' 3"	< 85	85 - 95	96 - 175	176 - 203	204 - 231	232 +
5' 4"	< 88	88 - 99	100 - 180	181 - 209	210 - 238	239 +
5' 5"	< 91	91 - 102	103 - 186	187 - 216	217 - 246	247 +
5' 6"	< 93	93 - 105	106 - 192	193 - 223	224 - 254	255 +
5' 7"	< 96	96 - 108	109 - 197	198 - 229	230 - 261	262 +
5' 8"	< 99	99 - 111	112 - 203	204 - 236	237 - 269	270 +
5' 9"	< 102	102 - 115	116 - 209	210 - 243	244 - 277	278 +
5' 10"	< 105	105 - 118	119 - 216	217 - 250	251 - 285	286 +
5' 11"	< 108	108 - 121	122 - 222	223 - 258	259 - 293	294 +
6' 0"	< 111	111 - 125	126 - 228	229 - 265	266 - 302	303 +
6' 1"	< 114	114 - 128	129 - 234	235 - 272	273 - 310	311 +
6' 2"	< 117	117 - 132	133 - 241	242 - 280	281 - 319	320 +
6' 3"	< 121	121 - 136	137 - 248	249 - 288	289 - 328	329 +
6' 4"	< 124	124 - 139	140 - 254	255 - 295	296 - 336	337 +
6' 5"	< 127	127 - 143	144 - 261	262 - 303	304 - 345	346 +
6' 6"	< 130	130 - 147	148 - 268	269 - 311	312 - 354	355 +
6' 7"	< 134	134 - 150	151 - 275	276 - 319	320 - 363	364 +
6' 8"	< 137	137 - 154	155 - 282	283 - 327	328 - 373	374 +
6' 9"	< 140	140 - 158	159 - 289	290 - 335	336 - 382	383 +
6' 10"	< 144	144 - 162	163 - 296	297 - 344	345 - 392	393 +
6' 11"	< 147	147 - 166	167 - 303	304 - 352	353 - 401	402 +
7' 0"	< 151	151 - 170	171 - 311	312 - 361	362 - 411	412 +
7' 1"	< 155	155 - 174	175 - 318	319 - 369	370 - 421	422 +
7' 2"	< 158	158 - 178	179 - 326	327 - 378	379 - 431	432 +
7' 3"	< 162	162 - 183	184 - 333	334 - 387	388 - 441	442 +
7' 4"	< 166	166 - 187	188 - 341	342 - 396	397 - 451	452 +




Agent Writing #

DNIS _____ Auth # _____


Group # (if applicable) _____

Keyline _____



United of Omaha Life Insurance Company
 A Mutual of Omaha Company

3300 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.

How Did You Hear About Us?

Please select all that apply. Thank you for providing this helpful information.

☐ Agent/Broker/Producer

☐ Family Member/Friend

☐ Physician Referral

☐ Social Media

☐ Direct Mail

☐ Internet Search

☐ Radio

☐ TV

A. Plan Information (to be completed by Producer)

Applicant A	Applicant B
Plan (select one): <input type="checkbox"/> Plan A <input type="checkbox"/> Plan G <div style="margin-left: 100px;"><input type="checkbox"/> High Deductible Plan G <input type="checkbox"/> Plan N</div> <p style="text-align: center;">OR</p> If your Medicare Part A eligibility date is before 01/01/2020, this additional plan is an available option: <input type="checkbox"/> Plan F	Plan (select one): <input type="checkbox"/> Plan A <input type="checkbox"/> Plan G <div style="margin-left: 100px;"><input type="checkbox"/> High Deductible Plan G <input type="checkbox"/> Plan N</div> <p style="text-align: center;">OR</p> If your Medicare Part A eligibility date is before 01/01/2020, this additional plan is an available option: <input type="checkbox"/> Plan F
Requested Effective Date / / 	Requested Effective Date / /
Deliver Policy to: Applicant A <input type="checkbox"/> Producer <input type="checkbox"/>	Deliver Policy to: Applicant B <input type="checkbox"/> Producer <input type="checkbox"/>

B. Applicant Information

Applicant A	Applicant B
Name (First/Middle Initial/Last)	Name (First/Middle Initial/Last)
Residence Address	Residence Address
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP 	State ZIP
Home Phone - - <small>(area code)</small>	Home Phone - - <small>(area code)</small>
If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? <input type="checkbox"/> Y <input type="checkbox"/> N	If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? <input type="checkbox"/> Y <input type="checkbox"/> N
E-mail Address	E-mail Address
Current Age _____	Current Age _____
Date of Birth / / <small>mo day yr</small>	Date of Birth / / <small>mo day yr</small>

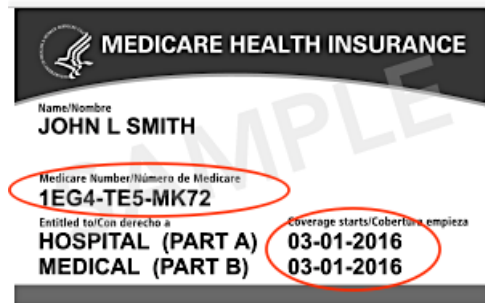
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B. Applicant Information (Continued)

Applicant A	Applicant B
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security # - 	Social Security # -
Height Weight Ft In Lbs 	Height Weight Ft In Lbs
Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N	Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? <input type="checkbox"/> Y <input type="checkbox"/> 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 <u>not</u> 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 United of Omaha Life Insurance Company.	
Receive statement online? <input type="checkbox"/> Y <input type="checkbox"/> N	Receive statement online? <input type="checkbox"/> Y <input type="checkbox"/> N

C. Medicare Information

Please reference your Medicare card to complete this section.



Applicant A	Applicant B
Medicare Number	Medicare Number
Medicare Part A Effective Date If you are not covered under Medicare Part A, what is your eligibility date 	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 	Medicare Part B Effective Date If you are not covered under Medicare Part B, indicate the date you plan to enroll

D. Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	Applicant A	Applicant B
1. Do you currently have a household resident (at least one, no more than three): (a) with whom you have continuously resided for the last 12 months and who is age 60 or older; or (b) with whom you reside and to whom you are either married or in a civil union partnership?..	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, except if both applicants are both applying for coverage on this application.		
Name (First/Middle/Last)		
Date of Birth		
Street Address		
City/State/ZIP		

E. 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:

	Applicant A	Applicant B
3. 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.) If "YES," answer the following about this existing coverage:	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(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

Please answer questions regarding another Medicare supplement or Select plan:

4. 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
If "YES," answer the following about this existing coverage:		
(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"/> <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"/> <input type="text"/> <input type="text"/>
(c) With what company, and what plan do you have?		

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

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

	Applicant A	Applicant B
5. 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).. If "YES," answer the following about this previous or existing coverage:	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(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"/> <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"/> <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"/> <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"/> <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"/> <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"/> <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) Is your former Medicare supplement or Medicare Select policy/certificate still available?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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:

6. 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

☐ Y ☐ N

Applicant B

☐ 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) Have you disenrolled from your current coverage voluntarily?..... ☐ Y ☐ N

(d) Please state the reason for your disenrollment:

Applicant A

Applicant B

(e) 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

F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

7. Are you applying during an open enrollment period?

(a) Did you turn age 65 in the last six months?.....

(b) Did you enroll in Medicare Part B in the last six months?.....

Applicant A

☐ Y ☐ N
☐ Y ☐ N

Applicant B

☐ Y ☐ N
☐ Y ☐ N

If either question 7a or 7b is "YES", indicate your Medicare Part B effective date

Applicant A

Applicant B

8. Are you applying during a guaranteed issue period?
(NOTE: Refer to the Guide to Health Insurance for People with Medicare to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)

☐ Y ☐ N

☐ Y ☐ N

STOP IF YOU ANSWER "YES" TO BOTH QUESTIONS 7A AND 7B OR QUESTION 8 IN SECTION F, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS G & H AND GO TO SECTION I.

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

(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)

G. Health Information

For all plans, answer questions 9-19. Note: An interviewer may call to confirm and verify the information you have provided on this application.

Part A: Medical Questions: (If "YES" is answered to any of the following questions 9-15, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
9. 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
10. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease (Stages 3, 4, or 5), 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), Huntington's disease, or cerebral palsy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic lupus, scleroderma or myasthenia gravis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Chronic hepatitis or cirrhosis?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Do you have Osteoporosis, and as a result, experienced a fracture?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Do you have an implanted cardiac defibrillator?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Part B: Medical Questions: (If "YES" is answered to any of the following questions 16-19 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
16. 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 artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any 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)?	<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 joint replacement?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
17. Do you have diabetes with high blood pressure and have you:		
A. Taken more than two medications for either condition (insulin dependent or oral medications)? ...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Had any changes in your medications within the past two years?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
18. 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
19. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment.

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H. Medication Information

If you are applying for **ANY** plan **OUTSIDE** of an open enrollment or guaranteed issue period, please answer the question. If "yes" list all over-the-counter or prescription medications you are currently taking or have been prescribed in the last 2 years.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
20. Are you currently taking, or have you been prescribed during the previous 2 years any prescription drugs or over-the-counter medications?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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	

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	

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I. 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 coverages.
- If you are age 65 or older, 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 UNITED OF OMAHA LIFE 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 Omaha Insurance Company, United World Life Insurance Company, Mutual of Omaha 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 United of Omaha Life Insurance Company. 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, United of Omaha Life 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 United of Omaha Life Insurance Company has taken action in reliance on the authorization or the law allows United of Omaha Life Insurance Company 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, including the presence of HIV infection, AIDS or ARC, 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 United of Omaha Life Insurance Company.

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 ____/____/____, _____
City State Month Day Year Applicant A's Signature

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

[illegible]

Applicant A
Applicant B

Applicant A
Applicant B


I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice.



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> Initial premium amount (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>1st through the 28th or the last day of every month</p> <p>Week (1st, 2nd, 3rd, 4th, last)</p> <p>Weekday (Mon, Tue, Wed, Thu, Fri)</p>	<p>1st through the 28th or the last day of every month</p> <p>Week (1st, 2nd, 3rd, 4th, last)</p> <p>Weekday (Mon, Tue, Wed, Thu, Fri)</p>
<p>Ongoing Premium Payments (Select option #1a, #1b, or #2)</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. Account Owner Name , if different than applicant's.....	_____	_____
2. If premium is NOT paid by Proposed Insured/Insured (includes spouse or joint-married account), 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

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.

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

Example:

Account Holder Name

Do NOT include the check # in the Routing or Account Number

John Doe

Street Address

Town, City ZIP Code

Pay to:

Date:

Check #1234

Routing/Transfer Number

Financial Institution Name & Address

Account Number

Dollars

123456789

12345678

1234

Memo

Signed By

I authorize United of Omaha Life Insurance Company ("United 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 United 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, United 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

Page 2

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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 United of Omaha Life 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

United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175

Applicant A

Signature
Date

Applicant B

Signature
Date

*Signature not required for direct response sales.



U7563_0619

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

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- ☐ 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

United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175

Applicant A

Signature 	Signature
Date	Date

Applicant B

Signature 	Signature
Date	Date

*Signature not required for direct response sales.



U7563_0619



Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175


Premium Receipt

All premiums must be made payable to United of Omaha Life 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, United of Omaha Life 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.

